

13380

CERTIFICATE OF DEATH

13312

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arnold</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arnold</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pines-on-the Severn Rd.</b>		d. STREET ADDRESS <b>Pines-on-the Severn Rd.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>John L Anderton</b>		4. DATE OF DEATH Month Day Year <b>December 11 19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 5, 1910</b>
9. AGE (In years last birthday) <b>50</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Baker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov.</b>	
11. BIRTHPLACE (State or foreign country) <b>Annapolis, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Anderton</b>		14. MOTHER'S MAIDEN NAME <b>Amada Lockett</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW II</b>	
17. INFORMANT <b>Mrs Emily I. Anderton</b>		Address <b>Wife Same As # 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> <b>420.1</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>ADW 1</b> , 19 <b>60</b> , to <b>12/11</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>12/10</b> , 19 <b>60</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Richard N. Peeler</b>		DATE SIGNED <b>12/14/60</b>	
PHYSICIAN'S NAME (Type) <b>RICHARD N. PEELER</b>		<b>ANNAPOLIS, MD</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-16-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Bluff Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Annapolis, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping Funeral Home</b>		ADDRESS <b>Annapolis, Maryland</b>	
24a. REC'D BY REGISTRAR <b>DEC 19 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1894

See Ord. No.

Name of Deceased		Sex		Age		Date of Birth	
John		Male		35		Jan 1, 1859	
Place of Birth		Cause of Death		Duration of Illness		Time of Death	
New York		Pneumonia		10 days		Jan 15, 1894	
Occupation		Profession		Education		Religion	
Teacher		Teacher		High School		Roman Catholic	
Marital Status		Previous Illnesses		Family History		Burial Place	
Married		None		None		St. Mary's Cemetery	
Signature of Physician		Signature of Registrar		Signature of Witness		Signature of Coroner	
[Signature]		[Signature]		[Signature]		[Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
13336  
CERTIFICATE OF DEATH

13313

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. LENGTH OF STAY IN 1b <b>RURAL Annapolis</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION (Dead on arrival) <b>Anne Arundel General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>FRANKLIN</b> Last <b>ARMIGER SR.</b>				4. DATE OF DEATH Month <b>December</b> Day <b>28</b> Year <b>1960</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAY 30, 1897</b>	
9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR Months <b>6</b> Days <b>3</b> Hours <b>3</b> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER + BRICKLAYER</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER + BRICKLAYER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>	
13. FATHER'S NAME <b>JOHN W. ARMIGER</b>				14. MOTHER'S MAIDEN NAME <b>LAURA M. KING</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WWI</b>				16. SOCIAL SECURITY NO. <b>202-05-1048</b>		17. INFORMANT <b>CHARLES E. ARMIGER</b> Address <b>#2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>9 mos</b> DUE TO (c) <b>9 mos</b>						INTERVAL BETWEEN ONSET AND DEATH <b>9 mos</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>9 mos</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>July 17, 1959</b> to <b>12-28-60</b> , that (I) (we) last saw the deceased alive on <b>12-22-60</b> , and that death occurred at <b>11 A.M.</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>A. T. Allen</b>				22b. DATE SIGNED <b>12/29/60</b>			
22c. PHYSICIAN'S NAME (Type) <b>A. T. Allen</b>				22d. ADDRESS <b>62 Cathedral St., Annapolis, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>12-31-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Marys Cemt.</b>		23d. LOCATION (City, town, or county) (State) <b>Annapolis Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Taylor Sons Annapolis, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>JAN 3 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

15313

UNITED STATES DEPARTMENT OF HEALTH  
BUREAU OF LABOR AND INDUSTRY - DIVISION OF HAZARDOUS MATERIALS

CERTIFICATE OF DRAIN

15336

Travel Properties

R.F.D. #3

MAY 30 1977 63

John M. Miller

John M. Miller & Son

CHS

10

St. Mary's

St. Mary's



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

M

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MEDICAL CERTIFICATION

<div> <div>13381</div> <div> <div>13381</div> <div>13381</div> </div> </div> <div> <div>13381</div> <div>13381</div> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Linthicum</u> c. LENGTH OF STAY IN 1b <u>Few seconds</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Route 8</u>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Galethorpe</u> d. STREET ADDRESS <u>5512 Willys Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <u>Anthony Vincent Bahor</u>						<b>4. DATE OF DEATH</b> Last <u>December</u> Month <u>13</u> Day <u>19</u> Year <u>60</u>					
<b>5. SEX</b> <u>M</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>8/29/34</u>		<b>9. AGE</b> (In years last birthday) <u>26</u> yrs. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Engineer's aide at Westinghouse</u>	
<b>11. BIRTHPLACE</b> (State or foreign country) <u>Pittsburg, Penn.</u>						<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>					
<b>13. FATHER'S NAME</b> <u>Michael Bahor</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>						<b>16. SOCIAL SECURITY NO.</b> <u>167-26-6338</u>		<b>17. INFORMANT</b> <u>Mrs. A.V. Bahor (wife)</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture of skull, fracture of left femur</u> DUE TO <u>812 X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Was fixing tire of Route 8 when was hit by another vehicle.</u>											
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Was fixing tire of Route 8 when was hit by another vehicle.</u>					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>8:45</u> a.m. <u>12/13/60</u> p.m. <u>19</u>						<b>20d. INJURY OCCURRED</b> <input checked="" type="checkbox"/> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Route 8</u>						<b>20f. (City or town)</b> <u>Linthicum</u> (County) <u>A.A.</u> (State) <u>Md.</u>					
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
<b>ACTUAL SIGNATURE</b> <u>Gustave N. Faubert M.D.</u>						<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>					
<b>EXAMINER'S NAME</b> (Type) <u>Gustave N. Faubert, M.D.</u>						<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>					
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>						<b>22b. DATE THEREOF</b> <u>Dec 17-60</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Holy Cross Cemetery</u>			
<b>23. FUNERAL DIRECTOR</b> <u>Bernard G. Fink</u>						<b>ADDRESS</b> <u>Glen Burnie Md.</u>		<b>24a. REC'D BY REGISTRAR</b> <u>DEC 16 '60</u>			
<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>						<b>24c. LOCATION</b> (City, town, or country) <u>Kelley Bay Brooklyn Md.</u> (State) <u>  </u>					

13381

1938

STATE OF TEXAS  
DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1938

NO. 1000  
JAN 10 1938

1

NAME OF DECEASED: \_\_\_\_\_

AGE: \_\_\_\_\_

SEX: \_\_\_\_\_

RACE: \_\_\_\_\_

DATE OF DEATH: \_\_\_\_\_

PLACE OF DEATH: \_\_\_\_\_

CAUSE OF DEATH: \_\_\_\_\_

MANNER OF DEATH: \_\_\_\_\_

SIGNATURE OF EXAMINER: \_\_\_\_\_

DATE: \_\_\_\_\_

08-2-1938

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
13382  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
13315  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
c. LENGTH OF STAY IN 1b <b>9 years 1 mos, 17 days</b>		d. STREET ADDRESS <b>845 Pierce Street</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Crownsville State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Annie</b> First <b>J.</b> Middle <b>Barnes</b> Last		4. DATE OF DEATH <b>12</b> Month <b>30</b> Year <b>60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1890?</b>
9. AGE (In years last birthday) <b>70?</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	
11. BIRTHPLACE (State or foreign country) <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>443X</b> IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO <b>Chronic Brain Syndrome associated with hyper-</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>tensive Cardiovascular Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized Arteriosclerosis</b>			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>11/13/60</b> to <b>12/30</b> , 19 <b>60</b> that (I) (we) last saw the deceased alive on <b>12/30</b> , and that death occurred at <b>11/13/60</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>L. Benedict</b>		22b. DATE SIGNED <b>12/30/1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. Benedict, M.D.</b>		22d. ADDRESS <b>Crownsville State Hospital, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>5-1-61</b>		23b. DATE THEREOF <b>5-1-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>University, Md.</b>		23d. LOCATION (City, town, or county) (State) <b>Beth, Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Reese mortuary</b>		25a. REC'D BY REGISTRAR <b>Anna, Md</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>		DATE <b>JAN 6 '61</b>	

13381

CERTIFICATE OF DEATH

13382

NAME: [illegible]  
AGE: [illegible]  
SEX: [illegible]  
DATE OF BIRTH: [illegible]  
PLACE OF BIRTH: [illegible]  
DATE OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
SIGNATURE: [illegible]  
DATE: [illegible]

Special Agent in Charge associated with report -  
[illegible]

General Agent in Charge associated with report -  
[illegible]

12/30/1930  
[illegible]

1. [illegible]  
[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13337

## CERTIFICATE OF DEATH

13316

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>4 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Clara</b> Middle <b>BARNES</b> Last <b>BARNES</b>		4. DATE OF DEATH Month <b>December</b> Day <b>15</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 26, 1890</b>
9. AGE (In years last birthday) <b>70 yrs.</b>		10. IF UNDER 1 YEAR Months <b>70</b> Days <b>70</b> Hours <b>70</b> Min. <b>70</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>?</b>		14. MOTHER'S MAIDEN NAME <b>?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>740</b>	
17. INFORMANT <b>Harrison Barnes</b>		Address <b>Rt. 1 Box 29 Annap. Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>260 X</b> DUE TO <b>Toxemia Pulmonary Edema</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Uncontrolled Diabetes, Gargano</b> (c) <b>?</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Annapolis</b> (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <b>Dec. 11, 1960</b> to <b>Dec. 15, 1960</b> , that (I) <b>did</b> last saw the deceased alive on <b>Dec. 15, 1960</b> , and that death occurred at <b>6:10 P.M.</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>A. T. Allen</b>		22b. DATE SIGNED <b>12/16/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. T. ALLEN</b>		22d. ADDRESS <b>62 Cathedral St., Annapolis, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-20-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>mt. Auburn</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>William Reese, 12 Anna. Md.</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 19 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>William S. Thomas</b>			

1981

1981





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 13353 CERTIFICATE OF DEATH

13317

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MARYLAND</u> <u>Anne Arundel</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			c. LENGTH OF STAY IN 1b <u>1</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Herondale</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>USNH, ANNAPOLIS, MARYLAND</u>				d. STREET ADDRESS <u>1801 Matravers Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>BILLINGS, Alfred Isadore</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>December 25 1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-8-93</u>		9. AGE (In years lost birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>USN (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (State or foreign country) <u>Louisiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Abraham Issac BILLINGS</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Ida LANGLOIS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>ww 1 and 11</u>		17. INFORMANT Address <u>Wife - 1801 Matravers Road, Herondale, Md.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Lung</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-16-60</u> , 19 <u>  </u> , to <u>12-25-60</u> , 19 <u>  </u> , that I last saw the deceased alive on <u>12-25-60</u> , 19 <u>  </u> , and that death occurred at <u>7:35A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>12-25-60</u> ACTUAL SIGNATURE <u>EC Keene</u> M.D.							
PHYSICIAN'S NAME (Type) <u>E. C. KEENE, LT MC USNR</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec 28-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Barby Pa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Donald Frank</u>				ADDRESS <u>Glen Burn Md</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 29 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
John Doe		Male		45		Jan 1, 1910		New York, N.Y.	
6. OCCUPATION		7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF DEATH		10. TIME OF DEATH	
Teacher		Heart Disease		Natural		Home		10:30 AM	
11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR		13. SIGNATURE OF WITNESSES		14. SIGNATURE OF DECEASED		15. SIGNATURE OF NEXT OF KIN	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
16. DATE OF DEATH		17. TIME OF DEATH		18. PLACE OF DEATH		19. SIGNATURE OF DECEASED		20. SIGNATURE OF NEXT OF KIN	
Jan 1, 1955		10:30 AM		Home		[Signature]		[Signature]	

NECESSARY, IF ANY DELAYED, TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

1  
FOR STATE HEALTH DEPT.

24 Maryland STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
1338 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13318

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Linthicum		c. LENGTH OF STAY IN 1b 1 year		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Same		b. COUNTY Same		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Same		d. STREET ADDRESS Same		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) King Brook Rd.		3. NAME OF DECEASED (Type or print) Leonard Joseph Blanchfield		4. DATE OF DEATH December 29 1960		5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/3/22		9. AGE (In years last birthday) 38 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationary Engineer at the Container Corp.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Blanchfield		14. MOTHER'S MAIDEN NAME Mary Shiroy		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give dates of service) Yes WWII Last world war		16. SOCIAL SECURITY NO. 215-14-0936		17. INFORMANT Mrs. Dorothy Blanchfield (wife)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: Stangulation (self) by tying a clothes line around his neck. IMMEDIATE CAUSE (a) DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. 974X		INTERVAL BETWEEN ONSET AND DEATH Sudden		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Tied one end of a rope to his neck and the other end to a door.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20c. TIME OF INJURY Month, Day, Year 4:30 P.M. 12/29/60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Linthicum, Md.		20g. (County) Anne Arundel		20h. (State) Md.		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 12/29/60 DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
ACTUAL SIGNATURE Gustave H. Faubert M.D.		EXAMINER'S NAME (Type) Gustave H. Faubert M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/2/1961		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem. Baltimore, Maryland		22d. LOCATION (City, town, or country) Baltimore, Maryland		24a. REC'D BY REGISTRAR JAN 3 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus							
23. FUNERAL DIRECTOR Howard H. Hubbard		ADDRESS 4107 Wilkens Ave.		24c. DATE JAN 3 '61		24d. REGISTRAR'S SIGNATURE Arthur L. Kraus															

13388 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

62-11-22

Howard, Howard 107 William Ave.

194-81

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

FOR STATE  
HEALTH DEPT.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
13384 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13319									
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> ✓				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Fort Meade</u>			c. LENGTH OF STAY IN lb <u>Few seconds</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Jessups</u>			d. STREET ADDRESS <u>Route 2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Fort Meade Hospital</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>GLENNA</u> <u>MARGARET</u> <u>BLAND</u>					4. DATE OF DEATH Month <u>December</u> Day <u>4</u> Year <u>1960</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/21/60</u>		9. AGE (In years last birthday) yrs. <u>3</u> Months <u>13</u> Days <u>13</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>			11. BIRTHPLACE (State or foreign country) <u>Seattle, Washington</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>									
13. FATHER'S NAME <u>Elbert Bland</u>					14. MOTHER'S MAIDEN NAME <u>Lucile Bunting</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>The parents</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Interstitial pneumonitis</u> <u>492X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) } (e), stating the underlying cause last. DUE TO (c) }					INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Russell S. Fisher</u> M.D.					CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>				
EXAMINER'S NAME (Type) <u>Russell S. Fisher, M.D.</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
					DATE SIGNED <u>12/5/60</u>				
					Address (Street, city, town, or county)				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>			22b. DATE THEREOF <u>12-8-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Cemetery</u>		22d. LOCATION (City, town, or country) <u>Seattle, Washington</u>		
23. FUNERAL DIRECTOR <u>Wm. Cook, Inc., 1217 St. Paul Street</u>					24a. REC'D BY REGISTRAR DATE <u>DEC 9 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Russell S. Fisher</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13338

CERTIFICATE OF DEATH

13320

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>aa</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>aa</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Is Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1128 Tyler Ave</u>				d. STREET ADDRESS <u>1128 Tyler Ave</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Frances Boettcher</u>				4. DATE OF DEATH Month Day Year <u>12-23 1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 16<sup>th</sup> 1904</u>		9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Sandy Hook N. J.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>Griffith H. Thomasson</u>				14. MOTHER'S MAIDEN NAME <u>Sallie Lou King</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>J. Earle Boettcher</u>		Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral aneurysm rupture</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>11<sup>th</sup> mos.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>60</u> , to <u>12-23</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>12-23</u> , 19 <u>60</u> , and that death occurred at <u>1:50</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. Linhardt</u>				ADDRESS (Street, city or town, state) <u>Chesapeake</u>		DATE SIGNED <u>12/28/60</u>	
PHYSICIAN'S NAME (Type) <u>E. Linhardt</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-26-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff Cent</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u>				ADDRESS <u>Annapolis Md</u>		24a. RECEIVED BY REGISTRAR DATE <u>DEC 26 60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hump</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

13339

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13321

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>9 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X RURAL - Lothian</b>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Ellen</b> Middle <b>NORA</b> Last <b>BRADY</b>		4. DATE OF DEATH Month <b>December</b> Day <b>13</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 14, 1883</b>
9. AGE (In years last birthday) <b>77 yrs.</b>	10. IF UNDER 1 YEAR Months <b>77</b> Days <b>77</b> Hours <b>77</b> Min. <b>77</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tenant</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>----- Hooper</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>N O</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Mrs. Wallace McKenzie-Lothian, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bacterial pneumonia</b> DUE TO <b>260X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral vascular accident</b> DUE TO <b>Diabetes mellitus</b> (c) <b>Dissecting aortic aneurysm</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <b>Dr. Emily H. Wilson</b> attended the deceased from <b>Aug. 1958</b> to <b>Dec. 12, 1960</b> , that (I) <b>last</b> saw the deceased alive on <b>Dec. 12, 1960</b> , and that death occurred at <b>3:55 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Emily H. Wilson</b>		22b. DATE SIGNED <b>12/13/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Emily H. Wilson</b>		22d. ADDRESS <b>Lothian, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/17/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Trinity Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Upper Marlboro, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ritchie Bros. Fun'l Home-Marlboro, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 20 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanks</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the other papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9-59

13340

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13322

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Peggy</b> Middle <b>Irene</b> Last <b>BRADY</b>		4. DATE OF DEATH Month <b>December</b> Day <b>20</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH <b>December 19, 1960</b>	9. AGE (In years lost birthday) <b>22</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
13. FATHER'S NAME <b>Joseph Basil BRADY</b>		14. MOTHER'S MAIDEN NAME <b>Dorothy Christine CLARKE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>776X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO <b>Prematurity</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (the hospital) attended the deceased from <b>Dec. 19, 19 60</b> to <b>Dec. 20, 19 60</b> , that (I) (we) last saw the deceased alive on <b>Dec. 20, 19 60</b> , and that death occurred at <b>3:00 P.M.</b> from the causes and on the date stated above. 22a. SIGNATURE <b>Clayton Norton</b> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <b>12/22/60</b> 22c. PHYSICIAN'S NAME (Type) <b>Clayton Norton</b> 22d. ADDRESS <b>Medical Building, Severna Park, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 23, 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt Zion</b>		23d. LOCATION (City, town, or county) (State) <b>Lothian, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping Funeral Home</b>		25a. REC'D BY REGISTRAR <b>DEC 27 '60</b>	
ADDRESS <b>Annapolis, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Clayton S. Harris</b>	

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1938

CERTIFICATE OF DEATH

1938

Blank certificate form with faint horizontal lines and a large circular stamp in the center.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
ISM 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13385

## CERTIFICATE OF DEATH

13323

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
c. LENGTH OF TIME IN PLACE (If outside corporate limits, write RURAL and give nearest town) <b>27 years 9 mos. 22 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>		d. STREET ADDRESS <b>226 Schroeder Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Thaddeus</b> Middle <b>Brice</b> Last <b>Brice</b>		4. DATE OF DEATH Month <b>12</b> Day <b>28</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/15/1888</b>
9. AGE (In years birth day) <b>72</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Samuel Brice</b>		14. MOTHER'S MAIDEN NAME <b>Sallie ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Type or print) <b>No</b> (If yes, give dates of service)		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Failure</b> <b>334X</b> DUE TO <b>Chronic Brain Syndrome associated with Cerebral and Generalized Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>General Paresis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>General Paresis</b> INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>9:25</b> p. m. 19 <b>60</b>			
20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <b>Crownsville State Hospital, Maryland</b>			
20f. (City or town) <b>Baltimore</b> (County) <b>md</b> (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>3/6/1933</b> to <b>12/28</b> , 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>12/28</b> , 19 <b>60</b> , and that death occurred at <b>9:25 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>L. Benedict, M. D.</b> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <b>Dec. 28, 1960</b> 22b. DATE SIGNED			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>12/29/60</b> 23b. DATE THEREOF <b>mt Auburn</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore md</b> 23d. LOCATION (City, town, or county) (State)			
24. FUNERAL DIRECTOR'S SIGNATURE <b>George H. Nelson</b> ADDRESS <b>1348 W. Calhoun St</b> 25a. REC'D BY REGISTRAR <b>JAN 3 '61</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

10088

CERTIFICATE OF DEATH

13-81

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. **TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
1334 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13324

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>aa</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>aa</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis 10</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>202 Prince George St.</i>				d. STREET ADDRESS <i>202 Prince George St.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Jean</i> Middle <i>Andrews</i> Last <i>Champion</i>				4. DATE OF DEATH Month <i>12</i> - Day <i>18</i> Year <i>1960</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Aug 22<sup>d</sup> 1900</i>	
9. AGE (In years last birthday) <i>60</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Hostess</i>		11. BIRTHPLACE (State or foreign country) <i>San Francisco Cal</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S A</i>	
13. FATHER'S NAME <i>Philip Andrews</i>				14. MOTHER'S MAIDEN NAME <i>Clara Fuller</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>(If yes, give war or dates of service)</i>				16. SOCIAL SECURITY NO.		17. INFORMANT <i>E. C. Champion 939 Hillcrest Circle Oakland Cal.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hyper Extensive Cerebral Ischemia</i> <i>443X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Sudden</i> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>E. Linhart</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>E. Linhart</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Dec 23-1960</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Arlington National</i>		22d. LOCATION (City, town, or county) (State) <i>Arlington Va</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i>				24a. REC'D BY REGISTRAR DATE <i>DEC 23 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

13325

13386

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Anne Arundel</b> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN 1b <b>15 yrs 10 mos 24 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				d. STREET ADDRESS <b>1730 Division Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Harry</b> Middle <b>Chester</b> Last <b>Chester</b>				<b>4. DATE OF DEATH</b> Month <b>12</b> Day <b>6</b> Year <b>1960</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 7, 1896</b>			
9. AGE (In years last birthday) <b>64</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>1</b> Hours <b>4</b> Min.		11. IF UNDER 24 HRS. Months <b>6</b> Days <b>1</b> Hours <b>4</b> Min.		12. IF UNDER 1 YEAR Months <b>6</b> Days <b>1</b> Hours <b>4</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			
13. FATHER'S NAME <b>Tom Chester</b>				14. MOTHER'S MAIDEN NAME <b>Laura Grant</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Hospital Records</b>		Address			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Decompensatory Heart Disease</b> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Cardiovascular Disease</b> DUE TO (c) <b>Arteriosclerotic Cardiovascular Disease</b>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <b>o. m.</b> <b>19</b> p. m. <b>6</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) <b>Baltimore</b> (County) <b>MD</b> (State) <b>MD</b>									
21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 12</b> 19 <b>65</b> to <b>Dec. 6</b> 19 <b>60</b> , that (I) (we) lost saw the deceased alive on <b>Dec. 6</b> 19 <b>60</b> , and that death occurred at <b>6A</b> from the causes and on the date stated above.									
22a. SIGNATURE <i>L. Benedict</i>				22b. DATE <b>December 6, 1960</b>					
22c. PHYSICIAN'S NAME (Type) <b>L. Benedict, M.D.</b>				22d. ADDRESS <b>Crownsville State Hospital, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-9-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>W.H. Burkley</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, MD</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert R. Williams</i>				25a. REC'D BY REGISTRAR <b>DEC 9 '60</b>		25b. REGISTRAR'S SIGNATURE <i>Charles S. Smith</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

13387 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
13327  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN 1b <b>6 yrs 4 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Louise</b> Middle Last <b>Cole</b>		4. DATE OF DEATH Month <b>12</b> Day <b>27</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1883 ?</b>
9. AGE (In years lost birthday) yrs. <b>77</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Atison Cole</b>		14. MOTHER'S MAIDEN NAME <b>Lucy ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO <b>Chronic Brain Syndrome associated with General Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <del>at</del> <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, _____) <b>factory, street, office bldg., etc.</b>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12/23</b> 19 <b>54</b> , to <b>12/27</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>12/27</b> 19 <b>60</b> , and that death occurred at <b>7:45</b> AM, from the causes and on the date stated above.			
22a. SIGNATURE <i>L. Benedict</i>		22b. DATE SIGNED <b>Dec. 27, 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. Benedict, M. D.</b>		22d. ADDRESS <b>Crownsville State Hospital, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/31/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Cedar Hill, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>E. O. Wilson</i>		25a. REC'D BY REGISTRAR <b>1000 Pennsylvania Ave.</b>	
25b. REGISTRAR'S SIGNATURE <i>Arthur E. Howard</i>		DATE <b>JAN 3 '61</b>	

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Married

Married

Children

6 yrs 4 mos

Children

1114 Commonwealth Avenue

Commonwealth State Hospital

Male

Female

1883

1880

Female

Domestic

Unknown

Virginia

Alison Cole

Lucy T

Psychiatric Hospital

Unknown

Urethra

Chronic renal syndrome associated with  
hypertension and arteriosclerosis



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1900

1901

1902

1903

1904

1905

1906

1907, 1908

Commonwealth State Hospital, Springfield, Mass.

1909, 1910

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 4, 3, 18, Film 279  
1/13/61 ams

**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

**13388 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13329**  
See: Birth Cert. et

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residencia before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Friendship</b>		c. LENGTH OF STAY IN lb <b>Friendship</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <b>DALE Gail LOUISE CREEK</b>		4. DATE OF DEATH Month Day Year <b>December 30 19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 30, 1960</b>
9. AGE (In years last birthday) yrs. <b>1</b>		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Friendship, Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Charles Creek</b>	
14. MOTHER'S MAIDEN NAME <b>Martha Jones</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intra-uterine Anoxia</b> <b>762.0</b> <b>XOUDOX</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pneumonitis due to Amnionitis.</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Petty</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Charles S. Petty, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>		22b. DATE THEREOF <b>12-6-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>City Morgue</b>		22d. LOCATION (City, town, or country) (State) <b>BALTO. Md</b>	
23. FUNERAL DIRECTOR ADDRESS		24a. REC'D BY REGISTRAR DATE <b>DEC 7 '60</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

VS. A15ME  
SM 7/59

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James H. Jones

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James H. Jones

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 13389  
 CERTIFICATE OF DEATH

13330

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Washington, D.C.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b>				c. LENGTH OF STAY IN 1b <b>8 years</b>			
d. NAME OF HOSPITAL, INSTITUTION, OR INSTITUTION <b>District Training School Children's Center</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Veronica</b> Middle <b>Darden</b> Last <b>Darden</b>				4. DATE OF DEATH Month <b>December</b> Day <b>27</b> Year <b>1960</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 9, 1950</b>	
9. AGE (In years last birthday) <b>10</b> yrs.		10. IF UNDER 1 YEAR Months <b>10</b> Days <b>10</b> Hours <b>10</b> Min.		11. BIRTHPLACE (State or foreign country) <b>D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Institutionalized</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>			
13. FATHER'S NAME <b>unknown</b>				14. MOTHER'S MAIDEN NAME <b>Mary Lee Darden</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>--</b>				16. SOCIAL SECURITY NO. <b>--</b>			
17. INFORMANT <b>Children's Center, Laurel, Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration</b> DUE TO <b>Severe spastic quadriplegia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Convulsive disorder</b> DUE TO (c) <b>Severe mental retardation</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Severe mental retardation</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>1/11/52</b> , 19 <b>1960</b> , that I last saw the deceased alive on <b>12/26/60</b> , 19 <b>1960</b> , and that death occurred at <b>12.30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Children's Center, Laurel, Md.</b> DATE SIGNED <b>12/27/60</b>							
ACTUAL SIGNATURE <b>James E. Boyland</b> M.D.				PHYSICIAN'S NAME (Type) <b>James E. Boyland, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>Dec 30, 1960</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>District Training School</b>				22d. LOCATION (City, town, or county) (State) <b>Laurel Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>John DeWester Dist. Supt. D.T.S.</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 4 '61</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>							

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

FOR STATE  
HEALTH DEPT.

M

I

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
13390 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13351									
1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Anne Arundel</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>				
c. LENGTH OF STAY IN 1b <u>8 1/2 years</u>					d. STREET ADDRESS <u>Same</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>103 Glenmount Avenue</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Richard Dorsey Davis</u>					4. DATE OF DEATH <u>December 14 1960</u>				
5. SEX <u>M</u>					6. COLOR OR RACE <u>W</u>				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>10/4/11</u>				
9. AGE (In years last birthday) <u>49</u>					10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk and Buyer at I.A. Benson Co.</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Md.</u>				
11. BIRTHPLACE (State or foreign country) <u>USA</u>					12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>Richard D. Davis Sr.</u>					14. MOTHER'S MAIDEN NAME <u>Iola Marie Norrie</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO. <u>2 16-05-9845</u>				
17. INFORMANT <u>Mrs. R.D. Davis (wife)</u>					Address <u>103 Glenmount Ave</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of lungs</u> DUE TO (b) <u>163x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>DUE TO</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death 8 months</u>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>									
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
22. ACTUAL SIGNATURE <u>Gustave H. Faubert M.D.</u>									
23. EXAMINER'S NAME (Type) <u>Gustave H. Faubert M.D.</u>									
24. CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
25. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
26. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>12/15/60</u>									
27. DATE SIGNED <u>12/15/60</u>									
28. ADDRESS (Street, city, town, or county)									
29a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>									
29b. DATE THEREOF <u>Dec 19-60</u>									
29c. NAME OF CEMETERY OR CREMATORY <u>London Mt Cemetery</u>									
29d. LOCATION (City, town, or county) (State) <u>Frederick Md Baltimore Md</u>									
23. FUNERAL DIRECTOR <u>Benjamin A. Zink</u>									
24. ADDRESS <u>4444 Baltimore Md</u>									
24b. REC'D BY REGISTRAR <u>DEC 19 '60</u>									
24c. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>									

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
13343 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13352									
1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY <b>Hazleton</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Battery A. Annandale, Md Turek</b>					c. LENGTH OF STAY IN 1b <b>75 X-3</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>					d. STREET ADDRESS <b>412 E. Mine Street</b>				
3. NAME OF DECEASED (Type or print) <b>ROBERT H. DEFRANCESSO</b>					4. DATE OF DEATH Month <b>December</b> Day <b>4</b> Year <b>1960</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/17/21</b>		9. AGE (In years last birthday) <b>39</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Service Man</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Army</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13. FATHER'S NAME <b>deceased (unknown)</b>					14. MOTHER'S MAIDEN NAME <b>Mary H. Franceschi (deceased)</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>					16. SOCIAL SECURITY NO. <b>171-03-3350</b>				
17. INFORMANT <b>Arthur S. Fisher</b>					Address <b>171-03-3350 Ft. Holibird Records, Ft. Holibird, Md</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple crushing injuries of abdomen, chest and head</b> DUE TO (b) <b>812X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>PARTIAL</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)									
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>Pedestrian struck by auto</b>				
20c. TIME OF INJURY Hour <b>7:00</b> p.m. Month, Day, Year <b>12/4/19 60</b>			20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Road</b>		20f. (City or town) (County) (State) <b>Anne Arundel, Md.</b>		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>Russell S. Fisher</b> M.D.					CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>				
EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
					DATE SIGNED <b>12/5/60</b>				
					Address (Street, city, town, or county)				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>			22b. DATE THEREOF <b>12/5/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>F.H. Bonini &amp; Son</b>		22d. LOCATION (City, town, or country) (State) <b>Hazleton, Penn.</b>		
23. FUNERAL DIRECTOR <b>Carl B. Robertson Funeral Home, Inc.</b> <b>6306-Belair Rd., Baltimore-6, Md.</b>					24a. REC'D BY REGISTRAR <b>DEC 9 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Fisher</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>             |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>6 hours</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Anne Arundel General Hospital</b>   |                                  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Ralph</b> Middle <b>Louis</b> Last <b>DICKINSON</b>  |                                  | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>29</b> Year <b>19 60</b>   |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>16 Jan., 1895</b> |
| 9. AGE (In years last birthday)<br><b>65</b> yrs.  |                                  | 10. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>             |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Gov. Printing Office</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Massachusetts</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>U.S.</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  |
| 13. FATHER'S NAME<br><b>Lewis Augustus Dickinson</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Emma Rebecca Cooley</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>Yes</b> (If yes, give war or dates of service)<br><b>WWI</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>17. INFORMANT</b><br><b>Irena Barden Dickinson, Same as 2</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br><b>260X</b> IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last.<br>(b) <b>Diabetic Acidosis</b><br>DUE TO<br>(c) <b>Diabetes Mellitus</b> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 minutes</b><br><b>24 hours</b><br><b>20 years</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. 19  |                                  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) <b>Dischman</b> attended the deceased from <b>Dec. 29</b> , 19 <b>60</b> , to <b>Dec. 29</b> , 19 <b>60</b> , that (I) <b>was</b> last saw the deceased alive on <b>Dec. 29</b> , 19 <b>60</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above.   |                                  |   |  |
| 22a. SIGNATURE<br><b>Richard C. Hockman</b>  |                                  | 22b. DATE SIGNED<br><b>12/30/60</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>R. I. Hockman</b>   |                                  | 22d. ADDRESS<br><b>100 Cathedral St., Annapolis, Md.</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>3 Jan, 1961</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill</b>  |                                  | 23d. LOCATION (City, town, or county) (State)<br><b>Washington, D.C.</b>  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Hopping &amp; Kirkley, Glen Burnie, Md.</b>   |                                  | 25a. REC'D BY REGISTRAR<br>DATE <b>JAN 4 '61</b>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Arthur S. ...</b>   |                                  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13334

13391

CERTIFICATE OF DEATH

|  |  |  |  |   |  |  |  |  |  |  |  |   |  |  |  |   |  |  |  |   |  |  |  |                   |  |  |  |                   |  |
|--|--|--|--|---|--|--|--|--|--|--|--|---|--|--|--|---|--|--|--|---|--|--|--|-------------------|--|--|--|-------------------|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Anne Arundel</b>  |  | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hanover</b> |  | c. LENGTH OF STAY IN 1b<br><b>12 yrs.</b>                                 |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Maryland</b>   |  | b. COUNTY<br><b>Anne Arundel</b>                                       |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hanover</b> |  | d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Box 121 Rt. 1 Ridge Road</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |  |  |   |  |  |  |                   |  |  |  |                   |  |
| 3. NAME OF DECEASED (Type or print)<br>First<br><b>EVA</b>   |  | Middle<br><b>C.</b>  |  | Last<br><b>DUCKWORTH</b>  |  | 4. DATE OF DEATH<br>Month<br><b>December</b>   |  | Day<br><b>11</b>   |  | Year<br><b>1960</b>  |  | 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>White</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>17th Nov. '72</b> |  | 9. AGE (In years last birthday)<br><b>88</b> yrs.   |  | IF UNDER 1 YEAR<br>Months<br><b>11</b> |  | Days<br><b>18</b> |  | IF UNDER 24 HRS.<br>Hours<br><b>18</b> |  | Min.<br><b>00</b> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>housework (ret.)</b>                             |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Garrett Co., Maryland</b> |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 13. FATHER'S NAME<br><b>Jesse O. Fazenbaker</b>                        |  | 14. MOTHER'S MAIDEN NAME<br><b>Margaret Ormond</b>   |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>   |  | 16. SOCIAL SECURITY NO.<br><b>none</b>   |  | 17. INFORMANT<br><b>Mrs. Margaret E. Matthews</b>   |  | Address<br><b>Same As #2</b>             |  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Cardiac Failure</b><br><b>782.4</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO<br>(c) DUE TO<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |                   |  |  |  |                   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)       |  | 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>     |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  | 20f. (City or town)<br>(County)<br>(State)   |  | 21. I certify that (I) (this hospital) attended the deceased from <b>March</b> 19 <b>52</b> to <b>December</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>December</b> 19 <b>60</b> , and that death occurred at <b>4:30</b> M, from the causes and on the date stated above. |  | 22a. SIGNATURE<br><b>Charles R. MacDonald MD</b>                                       |  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                        |  | 22b. DATE SIGNED<br><b>22</b>            |  |   |  |  |  |                   |  |  |  |                   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Charles R. MacDonald</b>  |  | 22d. ADDRESS<br><b>Glen Burnie Md</b>  |  | 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                |  | 23b. DATE THEREOF<br><b>21 st. Dec. '60</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Philos Cemetery</b>           |  | 23d. LOCATION (City, town, or county)<br><b>Westernport, Maryland</b>                              |  | 23e. (State)<br><b>Md</b>   |  | 25a. REC'D BY REGISTRAR<br><b>DEC 21 '60</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Carlton S. Huns</b>  |  |  |  |   |  |  |  |                   |  |  |  |                   |  |

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

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FOR STATE  
HEALTH DEPT.

13392 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13335

|  |  |                       |  |   |  |                                  |  |   |  |  |  |  |  |  |  |
|--|--|-----------------------|--|---|--|----------------------------------|--|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br>Anne Arundel   |  |                       |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE<br>Same   |  |                                  |  | b. COUNTY<br>Same   |  |  |  |  |  |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br>Pasadena   |  |                       |  | c. LENGTH OF STAY IN 1b<br>2 1/2 months   |  |                                  |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br>Same          |  |  |  |  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br>Lake Shore   |  |                       |  | d. STREET ADDRESS<br>1  |  |                                  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>Glen Ward Elgin  |  |                       |  | 4. DATE OF DEATH<br>December 19th. 1960   |  |                                  |  |   |  |  |  |  |  |  |  |
| 5. SEX<br>M  |  | 6. COLOR OR RACE<br>W |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br>12/19 8/5/60 |  | 9. AGE (In years last birthday)<br>4  |  | IF UNDER 1 YEAR<br>Months 4 Days 14        |  | IF UNDER 24 HRS.<br>Hours Min.                                     |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>None  |  |                       |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  |                                  |  | 11. BIRTHPLACE (State or foreign country)<br>Key West, Florida                                    |  |  |  | 12. CITIZEN OF WHAT COUNTRY?<br>USA                                |  |  |  |
| 13. FATHER'S NAME<br>Jimmy D. Elgin  |  |                       |  | 14. MOTHER'S MAIDEN NAME<br>Dorothy Smith   |  |                                  |  |   |  |  |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br>No  |  |                       |  | 16. SOCIAL SECURITY NO.<br>None   |  |                                  |  | 17. INFORMANT<br>Mrs. Jimmy Elgin (mother)  |  |  |  | Address  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Acute pulmonary infection.<br>527.2 DUE TO<br>Conditions, if any, which gave rise to immediate cause (b)<br>(a), stating the underlying cause last. DUE TO (c)  |  |                       |  |   |  |                                  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br>3 days |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |                       |  |   |  |                                  |  |   |  |  |  |  |  |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |                       |  |   |  |                                  |  |   |  |  |  |  |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  |                       |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |                                  |  |   |  |  |  |  |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m.<br>p.m.<br>19   |  |                       |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |                                  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                            |  |  |  | 20f. (City or town) (County) (State)                               |  |  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                       |  |   |  |                                  |  |   |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE<br>Gustave H. Faubert, M.D.   |  |                       |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |                                  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 12/19/60                                      |  |  |  | DATE SIGNED  |  |  |  |
| EXAMINER'S NAME (Type)<br>Gustave H. Faubert, M.D.   |  |                       |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |                                  |  | Address (Street, city, town, or county)<br>Glen Burnie, Md.                                       |  |  |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  |                       |  | 22b. DATE THEREOF<br>12-20-60   |  |                                  |  | 22c. NAME OF CEMETERY OR CREMATORY<br>Glen Haven Mem.   |  |  |  | 22d. LOCATION (City, town, or country) (State)<br>Glen Burnie, Md. |  |  |  |
| 23. FUNERAL DIRECTOR<br>Hopping & Birtley, Glen Burnie   |  |                       |  | 24a. REC'D BY REGISTRAR<br>DEC 23 '60   |  |                                  |  | 24b. REGISTRAR'S SIGNATURE<br>Arthur S. Kraus   |  |  |  |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13394

## CERTIFICATE OF DEATH

13336

Reg. Dist. No.

|  |   |  |  |   |  |  |  |
|--|---|--|--|---|--|--|--|
| <b>1. PLACE OF DEATH</b><br>o. COUNTY <u>Maryland</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie (Ferndale)</u><br>c. LENGTH OF STAY IN 1b <u>Yrs.</u><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>509 Old Annapolis Rd.</u>  |   |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>Maryland</u><br>b. COUNTY <u>Anne Arundel</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie (Ferndale)</u><br>d. STREET ADDRESS <u>509 Old Annapolis Rd.</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <u>Marian</u>  |   | First <u>Marian</u> Middle <u>Fink</u> Last <u>Fink</u>  |  | <b>4. DATE OF DEATH</b><br>Month <u>Dec.</u> Day <u>16</u> Year <u>1960</u>   |  |  |  |
| <b>5. SEX</b><br><u>Female</u>   | <b>6. COLOR OR RACE</b><br><u>White</u> | <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | <b>8. DATE OF BIRTH</b><br><u>29 Aug 1898</u>  | <b>9. AGE</b> (In years lost birthday) <u>82</u> yrs.   | <b>IF UNDER 1 YEAR</b><br>Months <u>8</u> Days <u>2</u> Hours <u>0</u> Min. <u>0</u> |  |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>Housework</u>   |   | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><u>Own Home</u>  |  | <b>11. BIRTHPLACE</b> (State or foreign country)<br><u>Baltimore, Md.</u>   |  |  |  |
| <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>U.S.A.</u>   |   |  | <b>13. FATHER'S NAME</b><br><u>Charles Turner</u>                                      |   |  |  |  |
| <b>14. MOTHER'S MAIDEN NAME</b><br><u>Ellen (unknown)</u>  |   |  | <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b><br>(Yes, no, or unknown) <u>No</u> |   |  |  |  |
| <b>16. SOCIAL SECURITY NO.</b><br><u>None</u>  |   |  | <b>INFORMANT</b><br><u>Elmer F. Fink</u> Address <u>Same As #2</u>                     |   |  |  |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u><br>(b) <u>Cardiac Insufficiency</u><br>(c) <u>Cardiac Insufficiency</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost.  |   |  |  |   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |  |  |   |  |  |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |   | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |  |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour o. m. p. m. <u>19</u>  |   | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)   |  |  |  |
| <b>20f. (City or town)</b>   |   | <b>(County)</b>  |  | <b>(State)</b>  |  |  |  |
| <b>21. I certify that I attended the deceased from</b> <u>12-15, 1960</u> <b>to</b> <u>12-16, 1960</u> , <b>that I last saw the deceased alive on</b> <u>12-15, 1960</u> , <b>and that death occurred at</b> <u>6 P.M.</u> <b>from the causes and on the date stated above.</b><br><b>ADDRESS</b> (Street, city or town, state) <u>3904 S. Hanover St.</u> <b>DATE SIGNED</b> <u>12-16-60</u><br><b>ACTUAL SIGNATURE</b> <u>Eugene Schritzer</u> <b>M.D.</b> |   |  |  |   |  |  |  |
| <b>PHYSICIAN'S NAME (Type)</b> <u>Eugene Schritzer</u>   |   |  |  |   |  |  |  |
| <b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br><u>Burial</u>  |   | <b>22b. DATE THEREOF</b><br><u>20th Dec. 1960</u>  |  | <b>22c. NAME OF CEMETERY OR CREMATORY</b><br><u>Holy Cross Cemetery</u>   |  |  |  |
| <b>22d. LOCATION</b> (City, town, or county)<br><u>Brooklyn RFD, Md.</u>   |   | <b>(State)</b>   |  |   |  |  |  |
| <b>23. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>R.V. Singleton</u>   |   | <b>ADDRESS</b><br><u>Glen Burnie, Md.</u>  |  | <b>24a. REC'D BY REGISTRAR</b><br><u>DEC 22 '60</u>   |  |  |  |
| <b>24b. REGISTRAR'S SIGNATURE</b><br><u>Arthur S. Hanna</u>  |   |  |  |   |  |  |  |

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CERTIFICATE OF DEATH

MARYLAND BUREAU OF VITALS - BALTIMORE 19

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13395

## CERTIFICATE OF DEATH

Reg. Dist. No.

13337

|  |                                  |  |  |   |   |   |   |
|--|----------------------------------|--|--|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>   |                                  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>Washington, D.C.</b> |   |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Laurel</b>  |                                  | c. LENGTH OF STAY IN lb<br><b>28 days</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Washington, D.C.</b>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>District Training School Children's Center</b>  |                                  |  |  | d. STREET ADDRESS<br><b>330 - 16th Street S.E.</b>  |   |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Barbara</b> Middle <b>Venette</b> Last <b>Fleet</b>  |                                  |  |  | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>29</b> Year <b>1960</b>  |   |   |   |
| 5. SEX<br><b>female</b>  | 6. COLOR OR RACE<br><b>Negro</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Feb. 18, 1960</b> |   | 9. AGE (In years lost birthday)<br><b>10</b> yrs. | IF UNDER 1 YEAR<br>Months <b>11</b> Days <b>11</b>  | IF UNDER 24 HRS.<br>Hours <b>11</b> Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Institutionalized</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>---</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Washington, D.C.</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>Carl Hubert Fleet</b>  |                                  |  |  | 14. MOTHER'S NAME<br><b>Gladys Rebecca Jones</b>  |   |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>---</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>---</b>  |  | INFORMANT Address<br><b>Children's Center, Laurel, Md.</b>  |   |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hydrocephalus</b><br><b>344X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO<br>(c) DUE TO |                                  |  |  |   |   |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |  |  |   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>---</b>                                       |  |   |   |   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <b>12/1/60</b> , 19 <b>60</b> , to <b>12/29/60</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>12/28/60</b> , 19 <b>60</b> , and that death occurred at <b>5:30A</b> M, from the causes and on the date stated above.                    |                                  |  |  |   |   |   |   |
| ACTUAL SIGNATURE <b>James E. Boyland</b> M.D.  |                                  |  |  | ADDRESS (Street, city or town, state) <b>Children's Center, Laurel, Md.</b> DATE SIGNED <b>12/29/60</b>   |   |   |   |
| PHYSICIAN'S NAME (Type) <b>James E. Boyland, M.D.</b>  |                                  |  |  | Children's Center, Laurel, Md. 12/29/60   |   |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial Jan. 3, 1961</b>  |                                  | 22b. DATE THEREOF<br><b>Jan. 3, 1961</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>ARLINGTON NATIONAL</b>   |   | 22d. LOCATION (City, town, or county) (State)<br><b>FT. MYER, VIRGINIA</b>                        |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>W. H. Pope</b>  |                                  |  |  | ADDRESS<br><b>414-15th S.E., WASH., D.C.</b>  |   | 24a. REC'D BY REGISTRAR<br>DATE <b>JAN 3 '61</b>  |   |
|  |                                  |  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur E. Brand</b>  |   |   |   |

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News

CERTIFICATE OF DEATH

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MADE IN A 20

CITY OF NEW YORK

DEPT. OF HEALTH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13396

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13338

|   |                               |  |                                       |   |  |  |  |
|---|-------------------------------|--|---------------------------------------|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> MARYLAND   |                               |  |                                       | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b> |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>   |                               |  |                                       | c. LENGTH OF STAY IN 1b <b>7mo. 20 days</b>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>  |                               |  |                                       | d. STREET ADDRESS <b>4432 St. George Ave.</b>   |  |  |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                               |  |                                       |   |  |  |  |
| 3. NAME OF DECEASED (Type or print)   |                               | First <b>William</b> Middle <b>Edwin</b> Last <b>Fletcher</b>  |                                       | 4. DATE OF DEATH  |  | Month <b>12</b> Day <b>9</b> Year <b>1960</b>                      |  |
| 5. SEX <b>Male</b>  | 6. COLOR OR RACE <b>Negro</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>June 29, 1903</b> |   | 9. AGE (In years last birthday) <b>57</b> yrs. | IF UNDER 1 YEAR Months Days Hours Min.                             |  |
| 10a. USUAL OCCUPATION (Give kind of work done during kind of working life, even if retired) <b>Carpenter</b>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>   |                                       | 11. BIRTHPLACE (State or foreign country) <b>Maryland</b>   |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                         |  |
| 13. FATHER'S NAME <b>John M. Fletcher</b>   |                               |  |                                       | 14. MOTHER'S MAIDEN NAME <b>Mary E. Jones</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>  |                               | 16. SOCIAL SECURITY NO. <b>216-01-1150</b>   |                                       | 17. INFORMANT <b>Hospital Records</b>   |  | Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>DUE TO <b>026 X</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>C.B.S. Abs. &amp; E.N.S. syphilis</b><br>DUE TO <b>Gastrectomy</b><br>(c) <b>-----</b> |                               |  |                                       |   |  |  | INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b><br><br><b>since Admission</b>                   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                               |  |                                       |   |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-----</b>  |                                       |   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <b>-----</b> 19<br>p. m. <b>-----</b>  |                               | 20d. INJURY OCCURRED While <b>at work</b> <input checked="" type="checkbox"/> at work <input type="checkbox"/>   |                                       | 20e. PLACE OF INJURY (Home, farm, factory, school, office bldg., etc.) <b>-----</b>   |  | 20f. (City or town) (County) (State)                               |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>4/19</b> <b>1960</b> , to <b>12/9</b> <b>1960</b> , that (I) (we) last saw the deceased alive on <b>12/9</b> <b>1960</b> , and that death occurred at <b>12AM</b> , from the causes and on the date stated above.  |                               |  |                                       |   |  |  |  |
| 22a. SIGNATURE <b>L. Benedict, M. D.</b>  |                               | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                                |                                       | 22b. DATE <b>12/9/60</b>  |  |  |  |
| 22c. PHYSICIAN'S NAME (Type)  |                               | 22d. ADDRESS <b>Crownsville State Hospital, Maryland</b>   |                                       |   |  |  |  |
| 23a. BURIAL, CREMATION, or other disposal (Specify) <b>Burial</b>   |                               | 23b. DATE THEREOF <b>12-13-60</b>  |                                       | 23c. NAME OF CEMETERY OR CREMATORY <b>Int. Calvary Cemetery</b>   |  | 23d. LOCATION (City, town, or county) (State) <b>Baltimore, Md</b> |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph L. Run</b>   |                               | ADDRESS <b>2222 W. North Ave</b>   |                                       | 25a. REC'D BY REGISTRAR <b>DEC 13 '60</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>                 |  |

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1938

UNITED STATES DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
STATE OF NEW YORK  
CERTIFICATE OF DEATH

1938

NAME OF DECEASED  
AGE  
SEX  
RACE  
DATE OF BIRTH  
PLACE OF BIRTH  
MARRIED  
OCCUPATION  
CAUSE OF DEATH  
PLACE OF DEATH  
DATE OF DEATH  
TIME OF DEATH  
SIGNATURE OF REGISTRAR  
SIGNATURE OF PHYSICIAN  
SIGNATURE OF CLERK

U.S. DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
STATE OF NEW YORK  
OFFICE OF THE REGISTRAR  
ALBANY, N.Y.

ALBANY, N.Y.

ALBANY, N.Y.

ALBANY, N.Y.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13345

## CERTIFICATE OF DEATH

13339

|  |                                  |   |   |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>             |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>X RURAL - Crownsville</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Anne Arundel General Hospital</b>   |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Bertha</b> Middle <b>E</b> Last <b>FORNEY</b>  |                                  | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>1</b> Year <b>1960</b>   |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Sept 3, 1879</b> |
| 9. AGE (In years last birthday)<br><b>81 yrs.</b>  |                                  | IF UNDER 1 YEAR<br>Months <b>81</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>House wife</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own home</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |   |
| 13. FATHER'S NAME<br><b>John Catterton</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>none</b>  |   |
| 17. INFORMANT<br><b>Mr. Robert L. Forney-Son- Same as # 2</b>  |                                  | Address   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Ac. Arterial insufficiency</b><br><b>274X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Ch. Arterial insufficiency</b> DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Plumicins anemia; Thyroid insufficiency</b> |                                  |   |   |
| INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hrs.</b>   |                                  |   |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  |   |   |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                  |   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) <del>physician</del> attended the deceased from <b>November 1959</b> to <b>Dec. 1, 1960</b> , that (I) <del>last</del> saw the deceased alive on <b>Dec. 1, 1960</b> , and that death occurred at <b>11:45 P.M.</b> from the causes and on the date stated above.   |                                  |   |   |
| 22a. SIGNATURE<br><b>Maurice Klawans</b>   |                                  | 22b. DATE SIGNED<br><b>12/2/60</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Maurice Klawans</b>   |                                  | 22d. ADDRESS<br><b>31 Southgate Ave., Annapolis, Md.</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>Dec. 5, 1960</b>  |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baldwin Memorial Cemetery</b>   |                                  | 23d. LOCATION (City, town, or county) (State)<br><b>Millersville, Maryland</b>  |   |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Hopping Funeral Home</b>  |                                  | 25a. REC'D BY REGISTRAR<br><b>DEC 7 '60</b>   |   |
| ADDRESS<br><b>Annapolis, Md.</b>   |                                  | 25b. REGISTRAR'S SIGNATURE<br><b>Colin S. Kraus</b>   |   |

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CENTRAL AIR OF DEATH

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by the funeral director. Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

13374 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|  |  |   |  |   |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
|--|--|---|--|---|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><u>Anne Arundel</u>  |  | b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Odenton</u>                                |  | c. LENGTH OF STAY IN 1b<br><u>8 years</u>   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>e. STATE<br><u>Same</u> |  | f. COUNTY<br><u>Same</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Same</u>   |  | d. STREET ADDRESS<br><u>Same</u>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                    |  |  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>"Boom Town" Annapolis Rd.</u>   |  | 3. NAME OF DECEASED<br>(Type or print)<br><u>George Gazda</u>   |  | 4. DATE OF DEATH<br>Month <u>12</u> Day <u>19</u> Year <u>1960</u>                                |  | 5. SEX<br><u>M</u>   |  | 6. COLOR OR RACE<br><u>W</u>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>5/5/14</u>  |  | 9. AGE (In years last birthday)<br><u>46</u> yrs.  |  | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u>   |  | IF UNDER 24 HRS.<br>Hours <u>  </u> Min. <u>  </u> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Self employed, Manager of bar.</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>of bar.</u>   |  | 11. BIRTHPLACE (State or foreign country)<br><u>Pennsylvania.</u>                                 |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |  | 13. FATHER'S NAME<br><u>John Gazda</u>   |  | 14. MOTHER'S MAIDEN NAME<br><u>UNKNOWN</u>  |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br><u>Miss. Gloria Barattini (step daughter)</u>   |  | Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Asphyxiation by smoke</u><br>916.6<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (b)<br>(c) DUE TO<br>(e), stating the underlying cause last.  |  | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>Few minutes</u>   |  | 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> |  | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 1b.)<br><u>Insisted upon going into hotel while in flames.</u>       |  | 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour <u>8</u> a.m. <u>  </u> p.m. <u>12/19/60</u> 19          |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>Hotel (main floor) Odenton A.A. Md.</u> |  | 20f. (City or town) (County) (State)               |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | ACTUAL SIGNATURE<br><u>Gustave H. Faubert, M.D.</u>   |  | EXAMINER'S NAME (Type)<br><u>Gustave H. Faubert, M.D.</u>   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  | DATE SIGNED<br><u>12/20/60</u>   |  | Address (Street, city, town, or county)  |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>   |  | 22b. DATE THEREOF<br><u>12-23-60</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Homestead Cemetery</u>                                   |  | 22d. LOCATION (City, town, or country) (State)<br><u>Homestead PA.</u>   |  | 23. FUNERAL DIRECTOR<br><u>Hopping &amp; Kirkley, Glen Burnie Md.</u>  |  | 24a. REC'D BY REGISTRAR<br><u>Arthur S. Kiana</u>   |  | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Kiana</u>   |  | DATE<br><u>DEC 23 '60</u>  |  |  |  |  |  |

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 13346 CERTIFICATE OF DEATH

13341

Reg. Dist. No.

|   |  |   |  |   |  |   |  |  |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|--|--|---|--|---|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>MARYLAND</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u><br>c. LENGTH OF STAY IN 1b <u>2 days</u><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>USNH, Annapolis, Maryland</u>                  |  |   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>ANNE ARUNDEL</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater</u><br>d. STREET ADDRESS <u>Wilelinor Estates</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |  |  |   |  |   |  |   |  |
| <b>3. NAME OF DECEASED</b> (Type or print)<br>First Middle Last<br><u>Karen Elizabeth GRANT</u>   |  |   |  | <b>4. DATE OF DEATH</b><br>Month Day Year<br><u>December 5th 1960</u>   |  |   |  |  |  |   |  |   |  |   |  |
| <b>5. SEX</b><br><u>Female</u>  |  | <b>6. COLOR OR RACE</b><br><u>White</u> |  | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | <b>8. DATE OF BIRTH</b><br><u>12-3-60</u>   |  | <b>9. AGE (In years lost birthday)</b><br><u>00 yrs.</u>         |  | <b>IF UNDER 1 YEAR</b><br>Months <u>00</u> Days <u>02</u> |  | <b>IF UNDER 24 HRS.</b><br>Hours <u>02</u> Min. <u>00</u> |  |   |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)  |  |   |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b>  |  |   |  | <b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u> |  |   |  | <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>            |  |   |  |
| <b>13. FATHER'S NAME</b><br><u>John Carleton Grant</u>  |  |   |  |   |  | <b>14. MOTHER'S MAIDEN NAME</b><br><u>Susan Ann Reichel</u>   |  |  |  |   |  |   |  |   |  |
| <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>   |  |   |  | <b>16. SOCIAL SECURITY NO.</b>  |  | <b>17. INFORMANT</b> Address <u>Father - Wilelinor Estates, Edgewater, Maryland</u>                 |  |  |  |   |  |   |  |   |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ATELECTASIS OF LUNGS</u><br>DUE TO (b) _____<br>DUE TO (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.                         |  |   |  |   |  |   |  |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH                          |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |  |   |  |   |  |  |  |   |  |   |  | <b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  |   |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) |  |  |  |   |  |   |  |   |  |
| <b>20c. TIME OF INJURY</b><br>Month, Day, Year<br>Hour o. m. p. m. <u>19</u>  |  |   |  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)                       |  | <b>20f. (City or town)</b> (County) (State)                      |  |   |  |   |  |   |  |
| <b>21. I certify that I attended the deceased from</b> <u>12/3</u> , 19 <u>60</u> , to <u>12/5</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>12/5</u> , 19 <u>60</u> , and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED |  |   |  |   |  |   |  |  |  |   |  |   |  |   |  |
| <b>ACTUAL SIGNATURE</b> M.D. <u>U.S. Naval Hospital, Annapolis, Md. 12-6</u>  |  |   |  |   |  |   |  |  |  |   |  |   |  |   |  |
| <b>PHYSICIAN'S NAME (Type)</b> <u>N. L. ZOURAS, LT MC USNR</u>  |  |   |  |   |  |   |  |  |  |   |  |   |  |   |  |
| <b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b>  |  |   |  | <b>22b. DATE THEREOF</b>  |  | <b>22c. NAME OF CEMETERY OR CREMATORY</b>   |  |  |  | <b>22d. LOCATION</b> (City, town, or county) (State)      |  |   |  |   |  |
| <u>Burial 12-6-60 U.S. Naval Academy Annapolis Md.</u>  |  |   |  | <u>12-6-60</u>  |  | <u>U.S. Naval Academy</u>   |  |  |  | <u>Annapolis Md.</u>                                      |  |   |  |   |  |
| <b>23. FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS   |  |   |  |   |  | <b>24. REC'D BY REGISTRAR</b>   |  | <b>25. REGISTRAR'S SIGNATURE</b>                                 |  |   |  |   |  |   |  |
| <u>John M. Taylor Saw Annapolis Md.</u>   |  |   |  |   |  | <u>DEC 8 '60</u>  |  | <u>Charles L. Kline</u>  |  |   |  |   |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

2051212XV3





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
13397  
CERTIFICATE OF DEATH

13342

|   |                                  |   |  |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>             |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural-Pasadena</b>   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>X Pasadena</b>   |  |
| c. LENGTH OF STAY IN 1b<br><b>35 yrs</b>  |                                  | d. STREET ADDRESS<br><b>Box 185 Route 2 Rock Creek</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Residence.</b>   |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>GEORGE</b> Middle <b>MILTON</b> Last <b>GRAY</b>  |                                  | 4. DATE OF DEATH<br>Month <b>Monday</b> Year <b>1960</b><br><b>December 5th,</b>  |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>June 26, 1886</b> |
| 9. AGE (In years last birthday)<br><b>74</b> yrs.   |                                  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Carpenter &amp; Helper</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Gen'l House Reprs. Anne Arundel Co Md</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>USA</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>Wm C. Gray</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth F Harrison</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>219-01-7177</b>   |  |
| 17. INFORMANT<br><b>Mrs May L Gray (Wife-Widow)</b>   |                                  | Address<br><b>SAME</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>331X cerebro-vascular accident</b><br>DUE TO (b) <b>generalized arteriosclerosis</b><br>DUE TO (c) <b>2 years</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>10 hours</b><br><b>2 years</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>none</b>  |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) ( <del>his hospital</del> ) attended the deceased from <b>June 10, 1954</b> to <b>Dec. 5, 1960</b> , that (I) ( <del>lost</del> ) lost the deceased alive on <b>Dec. 1, 1960</b> , and that death occurred at <b>6 PM</b> , from the causes and on the date stated above.  |                                  |   |  |
| 22a. SIGNATURE<br><b>R.M. McLaughlin</b>  |                                  | 22b. DATE SIGNED<br><b>12/5/60</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>R.M. McLaughlin</b>  |                                  | 22d. ADDRESS<br><b>3708 Mountain Rd. Pasadena, Md.</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                                  | 23b. DATE THEREOF<br><b>DEC 8, 1960</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cem</b>   |                                  | 23d. LOCATION (City, town, or county) (State)<br><b>Brooklyn AA Co Md</b>   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>A. Howard Evans &amp; Son</b>  |                                  | 25a. REC'D BY REGISTRAR<br><b>DEC 6 '60</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Evans</b>  |                                  |   |  |

13333

CERTIFICATE OF DEATH

13333

NAME

RESIDENCE

RESIDENCE

CHARGE

GRAY

WHITE

1000

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1000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

CERTIFICATE OF DEATH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13347

CERTIFICATE OF DEATH

13343

|   |                               |  |   |
|---|-------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> MARYLAND   |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>          |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>   |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - Annapolis</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>(Dead on arrival) Anne Arundel General Hospital</b>   |                               | d. STREET ADDRESS <b>1 Rt-1, Bon Haven</b>   |   |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>   |                               |  |   |
| 3. NAME OF DECEASED (Type or print) First <b>Mario</b> Middle <b>P</b> Last <b>GRAZIOLI</b>   |                               | 4. DATE OF DEATH Month <b>December</b> Day <b>12</b> Year <b>1960</b>  |   |
| 5. SEX <b>Male</b>  | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>February 20, 1911</b> |
| 9. AGE (In years lost birthday) <b>49</b> yrs.  |                               | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dept of Defense at Ft Meade Md</b>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>Pennsylvania</b>  |   |
| 11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>   |                               | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>  |   |
| 13. FATHER'S NAME <b>Dominic Grazzoli</b>   |                               | 14. MOTHER'S MAIDEN NAME <b>Maria Endrizzi</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>  |                               | 16. SOCIAL SECURITY NO. <b>—</b>   |   |
| 17. INFORMANT <b>Geraldine L. Grazzoli</b> Address <b>(2)</b>   |                               |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>420.1 Acute myocardial infarction</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>—</b><br>DUE TO (c) <b>—</b> |                               | INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs.</b>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>—</b>  |                               | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>   |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                               | 20f. (City or town) (County) (State)   |   |
| 21. I certify that (I) <b>(physician)</b> attended the deceased from <b>Jan 1960</b> to <b>Dec 1960</b> , that (I) <b>(see)</b> last saw the deceased alive on <b>July 1</b> 19 <b>60</b> , and that death occurred at <b>11:00 A.M.</b> from the causes and on the date stated above.                                    |                               |  |   |
| 22a. SIGNATURE <b>John L. Hedeman</b>   |                               | 22b. DATE SIGNED <b>DEC 15 '60</b>   |   |
| 22c. PHYSICIAN'S NAME (Type) <b>John L. Hedeman</b>   |                               | 22d. ADDRESS <b>121 Cathedral St., Annapolis, Md.</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |                               | 23b. DATE THEREOF <b>Dec 16-1960</b>   |   |
| 23c. NAME OF CEMETERY OR CREMATORY <b>St Marys</b>  |                               | 23d. LOCATION (City, town, or county) (State) <b>Annapolis Md</b>  |   |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Taylor</b>  |                               | 25a. REC'D BY REGISTRAR <b>DEC 15 '60</b>  |   |
| 25b. REGISTRAR'S SIGNATURE <b>Arthur L. Knapp</b>   |                               |  |   |

13347

CERTIFICATE OF DEATH

13347

For use in

State of

State of

County of

County of

City of

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13348

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 14 Film 6276 12-16-60 et

13344

Reg. Dist. No.

|   |                                  |   |                                       |
|---|----------------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>AA</u><br>MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Md.</u> b. COUNTY <u>AA</u>                            |                                       |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Annapolis</u>  |                                  | c. LENGTH OF STAY IN 1b<br><u>Wilhelmina Estates</u>  |                                       |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>A.A. General Hospt.</u>  |                                  | e. STREET ADDRESS<br><u>1 P.D. # 2 Annapolis</u>  |                                       |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><u>Terry Saxon Green III</u>  |                                  | 4. DATE OF DEATH<br>Month Day Year<br><u>12-6-1960</u>  |                                       |
| 5. SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Apr 3-1930</u> |
| 9. AGE (In years last birthday)<br><u>30</u> yrs.   |                                  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |                                       |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Marketing Ordance Dept Westinghouse</u>  |                                  | 12. KIND OF BUSINESS OR INDUSTRY<br><u>St Paul Minst. N.S.A.</u>  |                                       |
| 13. FATHER'S NAME<br><u>Terry S. Green II</u>   |                                  | 14. MOTHER'S MAIDEN NAME<br><u>Jacqueline Webster</u>   |                                       |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>yes</u>  |                                  | 16. SOCIAL SECURITY NO.<br><u>1930-38</u>   |                                       |
| 17. INFORMANT<br><u>Pauline B. Green</u>  |                                  | Address<br><u>(2)</u>   |                                       |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Multiple Injuries</u><br>825x DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____<br>INTERVAL BETWEEN ONSET AND DEATH<br><u>immediate</u> |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                       |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>auto accident</u>  |                                       |
| 20c. TIME OF INJURY<br>Month, Day, Year<br><u>12-10-1960</u><br>Hour a.m. p.m.<br><u>12:10 a.m.</u>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>  |                                       |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>At. 50</u>   |                                  | 20f. (City or town) (County) (State)<br><u>AAco MD</u>  |                                       |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .  |                                  |   |                                       |
| ACTUAL SIGNATURE<br><u>John M. Seyler</u>   |                                  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |                                       |
| EXAMINER'S NAME (Type)<br><u>F. Linhardt</u>  |                                  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |                                       |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                                  | 22b. DATE THEREOF<br><u>12-9-1960</u>   |                                       |
| 22c. NAME OF CEMETERY OR CREMATORY<br><u>Arlington National</u>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><u>Arlington Va</u>  |                                       |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>John M. Seyler</u>   |                                  | 24a. REC'D BY REGISTRAR<br><u>DEC 8 '60</u>   |                                       |
| 24b. REGISTRAR'S SIGNATURE<br><u>C. S. Kraus</u>  |                                  | DATE<br><u>DEC 8 '60</u>  |                                       |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

342



## CERTIFICATE OF DEATH

Reg. Dist. No.

13345

13398

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>A.A.</b> <b>MARYLAND</b>   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>A.A.</b> b. COUNTY                                     |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>BROOKLYN</b>  |   | c. LENGTH OF STAY IN 1b   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>III SIXTH AVENUE</b>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>MATILDA</b> Middle <b>GREGOR</b> Last   |   | 4. DATE OF DEATH<br><b>12/6/60</b> Month Day Year   |   |
| 5. SEX<br><b>F</b>   | 6. COLOR OR RACE<br><b>W</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>6/30/84</b>  |
| 9. AGE (In years last birthday) yrs.<br><b>76</b>  |   | IF UNDER 1 YEAR<br>Months Days  | IF UNDER 24 HRS.<br>Hours Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>NONE</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>   |   | 12. CITIZEN OF WHAT COUNTRY?  |   |
| 13. FATHER'S NAME<br><b>GOTTLIEB NIERNBERG</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>AUGUSTINA</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)   |   | 16. SOCIAL SECURITY NO.<br><b>INFORMANT</b> Address <b>FAMILY - SAME</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b><br>DUE TO (b) <b>Arterio-sclerotic Cardio-renal Disease</b><br>DUE TO (c) <b>Diabetes Mellitus</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 days</b><br><b>10 years</b><br><b>2</b>                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that I attended the deceased from <b>4/25</b> 19 <b>57</b> to <b>12/6</b> 19 <b>60</b> that I last saw the deceased alive on <b>12/5</b> 19 <b>60</b> , and that death occurred at <b>1226</b> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>1226 Hanover St.</b> DATE SIGNED<br>ACTUAL SIGNATURE <b>Harry Deibel</b> M.D.<br>PHYSICIAN'S NAME (Type) <b>DR. HARRY DEIBEL</b> |   |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>B</b>  | 22b. DATE THEREOF<br><b>12/10/60</b>  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>GLEN HAVEN</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>BALTIMORE</b>                                 |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br>ADDRESS<br><b>MCCULLY - 130 EAST FORT AVENUE</b>   |   | 24a. REC'D BY REGISTRAR<br>DATE <b>DEC 9 '60</b>  | 24b. REGISTRAR'S SIGNATURE<br><b>C. J. L. K...</b>  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

13338

DECEASED

ALL STATE AVENUE

CHICAGO, ILL.

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

### CERTIFICATE OF DEATH

13346

|  |  |   |  |
|--|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>A.A. Co.</u> <b>MARYLAND</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Orchard Beach</u><br>c. LENGTH OF STAY IN 1b<br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1210 Beach Promenade</u>  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>md</u> b. COUNTY <u>A.A. Co.</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Orchard Beach</u><br>d. STREET ADDRESS <u>1210 Beach</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| <b>3. NAME OF DECEASED</b> (Type or print) <u>Waisy T. Griffith</u><br>First Middle Last<br>5. SEX <u>F.</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Jan 21, 1888</u><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years lost birthday) <u>72</u> yrs. 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min. |  | <b>4. DATE OF DEATH</b> <u>Dec. 2/60</u> 19 <u>19</u><br>Month Day Year<br>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Corn Home</u> 11. BIRTHPLACE (State or foreign country) <u>Balto. Md</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>                                       |  |
| 13. FATHER'S NAME <u>Schrader</u> 14. MOTHER'S MAIDEN NAME <u>Eliz. —</u>  |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 17. INFORMANT <u>Allen R. Griffith</u> Address <u>Orchard Beach</u>  |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of the descending colon</u><br>153.2 DUE TO (b) <u>4 months</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)   |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  | 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 <u>July 1, 1955</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>July 1, 1955</u> to <u>December 2, 1960</u> , that (I) <u>lost</u> saw the deceased alive on <u>December 2, 1960</u> , and that death occurred at <u>9:15 P.M.</u> from the causes and on the date stated above.  |  |   |  |
| 22a. SIGNATURE <u>R. M. McLaughlin</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>12/2/60</u>  |  | 22c. PHYSICIAN'S NAME (Type) <u>R. M. McLaughlin</u> 22d. ADDRESS <u>3708 Mountain Rd. Pasadena, Md.</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>12/6/60</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u> 23d. LOCATION (City, town, or county) (State) <u>Glenburnie, Md</u>  |  | 24. FUNERAL DIRECTOR'S SIGNATURE <u>Witke F. N. 4101 Edmondson</u> ADDRESS <u>4101 Edmondson</u> 25a. REC'D BY REGISTRAR DATE <u>DEC 5 '60</u> 25b. REGISTRAR'S SIGNATURE <u>Carlton S. Kraus</u>   |  |

may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1833

STATE OF ALABAMA  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

1833

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the document. The text appears to contain names, dates, and possibly a description of the deceased.]*

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

13347

13399

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Greenland Beach</b>      |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Greenland Beach</b>                                      |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>426 Greenland Beach Road</b> |  | d. STREET ADDRESS<br><b>426 Greenland Beach Road</b>  |  |
|   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |

|   |                                  |   |  |
|---|----------------------------------|---|--|
| 3. NAME OF DECEASED (Type or print)<br><b>Mary Beatrice Gruss</b>   |                                  | 4. DATE OF DEATH<br>Month <b>Dec.</b> Day <b>26</b> , Year <b>1960</b>  |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>April 22, 1881</b>                    |
| 9. AGE (In years last birthday)<br><b>79 yrs</b>  |                                  | IF UNDER 1 YEAR<br>Months Days Hours  | IF UNDER 24 HRS.<br>Min.                                     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b> |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b> |
|   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>  |  |

|   |  |  |  |
|---|--|--|--|
| 13. FATHER'S NAME<br><b>James McNaney</b>                                       |  | 14. MOTHER'S MAIDEN NAME<br><b>Julia (Unk)</b>                           |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b> |  | 16. SOCIAL SECURITY NO.<br><b>(If yes, give war or dates of service)</b> |  |
| 17. INFORMANT<br><b>Mrs. Alice Germershausen 1239 Battery Ave.</b>              |  | Address  |  |

|  |  |   |
|--|--|---|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma Colon</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>153.8</b><br>DUE TO<br>(c) |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>8 months</b> |
|--|--|---|

|   |  |   |
|---|--|---|
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|---|--|---|

|  |   |  |                                      |
|--|---|--|--------------------------------------|
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |                                      |
| 20c. TIME OF INJURY<br>Month. Day. Year<br>Hour a. m. p. m.<br><b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                       | 20f. (City or town) (County) (State) |

21. I certify that (I) (this hospital) attended the deceased from **Feb** 19**60** to **Dec 25** 19**60** that (I) (we) last saw the deceased alive on **12/24/60** 19**60**, and that death occurred at **11** M, from the causes and on the date stated above.

|  |  |  |
|--|--|--|
| 22a. SIGNATURE<br><b>J. Brady Smith</b>            | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22b. DATE SIGNED<br><b>Dec. 26, 1960</b> |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Brady Smith</b> | 22d. ADDRESS<br><b>Ft. Smallwood Rd. Riviera Beach A. A. Co. Md</b>  |  |

|  |   |   |  |
|--|---|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> | 23b. DATE THEREOF<br><b>Dec. 28, 1960</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral Cemetery</b> | 23d. LOCATION (City, town, or county) (State)<br><b>Frederick Road, Baltimore, Md.</b> |
|--|---|---|--|

|   |                                      |   |  |
|---|--------------------------------------|---|--|
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Krause Funeral Home - 1216 S. Charles St</b><br><b>Doris P. Krause</b> | ADDRESS<br><b>1216 S. Charles St</b> | 25a. REC'D BY REGISTRAR<br>DATE <b>DEC 28 '60</b> | 25b. REGISTRAR'S SIGNATURE<br><b>Charles E. Krause</b> |
|---|--------------------------------------|---|--|

18347

CERTIFICATE OF DEATH

18347

|                |                 |
|----------------|-----------------|
| NAME           | ANNE STANLEY    |
| RESIDENCE      | GREENHILL, IOWA |
| DATE OF BIRTH  | 1871            |
| DATE OF DEATH  | 1910            |
| PLACE OF DEATH | GREENHILL, IOWA |
| Cause of Death | Heart Disease   |
| Physician      | Dr. J. H. Smith |
| Funeral Home   | Greenhill, Iowa |
| Interment      | Greenhill, Iowa |
| Signature      | [Signature]     |
| Witness        | [Signature]     |
| Registrar      | [Signature]     |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

| DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND   |  |   |   |   |   |   |  |  |  |  |
|--|--|---|---|---|---|---|--|--|--|--|
| 13349  |  |   |   |   |   |   |  |  |  |  |
| 13348  |  |   |   |   |   |   |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> MARYLAND  |  |   |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> |   |  |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>   |  |   | c. LENGTH OF STAY IN 1b   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>10 Annapolis</b>   |   |  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Anne Arundel General Hospital</b>   |  |   |   |   | d. STREET ADDRESS<br><b>1322 Bayridge Ave.,</b>   |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Ethel</b> Middle <b>May</b> Last <b>HARLEY</b>  |  |   |   |   | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>16</b> Year <b>19 60</b>   |   |  |  |  |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b>  |   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><b>October 24, 1903</b>                               |  | 9. AGE (In years last birthday)<br><b>57</b> yrs.                                      |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Checker</b>  |  |   |   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Dry Cleaners</b>  |   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                 |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>          |  |
| 13. FATHER'S NAME<br><b>Walter Phipps</b>  |  |   |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Maude McCoy</b>  |   |  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>n</b>  |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(If yes, give war or dates of service)<br><b>no</b> |   | 16. SOCIAL SECURITY NO.<br><b>216-05-0766</b>   |   | 17. INFORMANT<br><b>James Dudley Phipps, Brother- Adml, Hgts, Annapo-</b> |  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Valvular, distal glomer</b><br><b>5703</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Coronary artery disease</b> |  |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days.</b>  |   |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |  |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>   |  |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)   |  |  |  |
| 21. I certify that (I) <b>(physician)</b> attended the deceased from <b>Dec. 14, 1960</b> to <b>Dec. 16, 1960</b> , that (I) <b>(last saw the deceased alive on Dec. 16, 1960)</b> , and that death occurred at <b>M</b> from the causes on and on the date stated above.<br><b>11:20 A.M.</b>   |  |   |   |   |   |   |  |  |  |  |
| 22a. SIGNATURE<br><b>Maurice Klawans</b> M.D.  |  |   |   |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                 |   |  | 22b. DATE SIGNED<br><b>12/16/60</b>  |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Maurice Klawans</b>   |  |   |   |   | 22d. ADDRESS<br><b>31 Southgate Ave., Annapolis, Md.</b>  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |   | 23b. DATE THEREOF<br><b>Dec. 20, 1960</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>All Hallows</b>  |   | 23d. LOCATION (City, town, or county) (State)<br><b>Birdsville, Maryland</b> |  |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Hopping Funeral Home</b>  |  |   |   |   | ADDRESS<br><b>Annapolis, Md</b>   |   | 25a. REC'D BY REGISTRAR<br><b>DEC 27 '60</b>                                 |  | 25b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hanks</b> |  |

1894

CERTIFICATE OF DEATH

1894

Blank certificate form with faint lines and text, including fields for name, date, and cause of death. The text is mirrored and mostly illegible.

# 1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/69

## MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13400

13349

|   |   |  |  |
|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Anne Arundel</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Linthicum</b><br>c. LENGTH OF STAY IN 1b<br><b>Life</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>300 South Camp Meade Road.</b>  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE<br><b>Same</b><br>b. COUNTY<br><b>Same</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Same</b><br>d. STREET ADDRESS<br><b>Same</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Wendy Lee Hartung</b>  |   | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>6th.</b> Year <b>19 60</b>  |  |
| 5. SEX<br><b>F</b>  | 6. COLOR OR RACE<br><b>W</b>              | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>10/13/60</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>None</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Fort Meade Hospital, Md.</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>USA</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 13. FATHER'S NAME<br><b>James W. Hartung</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Joan Sullivan</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |   | 16. SOCIAL SECURITY NO.<br><b>None</b>   |  |
| 17. INFORMANT<br><b>Mr. and Mrs. J.W. Hartung (parents)</b>   |   | Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>754.5 Congenital heart diseases</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (b)<br>(a), stating the underlying cause last. (c) DUE TO<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b> |   |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |   | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>  |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  |   |  |  |
| ACTUAL SIGNATURE<br><b>Gustave H. Faubert, M.D.</b>   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |
| EXAMINER'S NAME (Type)<br><b>Gustave H. Faubert, M.D.</b>   |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |   | DATE SIGNED<br><b>12/6/60</b>  |  |
| Address (Street, city, town, or county)   |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 22b. DATE THEREOF<br><b>8th Dec. 1960</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Lakeview Cemetery</b>   | 22d. LOCATION (City, town, or country) (State)<br><b>Jamestown, New York</b> |
| 23. FUNERAL DIRECTOR<br><b>R. J. Singleton</b>  |   | ADDRESS<br><b>Glen Burnie, Maryland</b>  |  |
| 24a. REC'D BY REGISTRAR<br><b>DEC 7 60</b>  |   | 24b. REGISTRAR'S SIGNATURE<br><b>Carroll S. [Signature]</b>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13350

13375

|  |                                |  |   |  |   |
|--|--------------------------------|--|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Anne Arundel</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Odenton, Md</b><br>c. LENGTH OF STAY IN 1b<br><b>United States Army Hospital</b><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Ft Geo. G. Meade, Md.</b> |                                |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Anne Arundel</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>X Ft. George G. Meade</b><br>d. STREET ADDRESS<br><b>7311-E Gammons</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>EVA MARIE Hartwig</b>   |                                |  | 4. DATE OF DEATH<br>Month Day Year<br><b>12 11 19 60</b>  |  |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>Cau</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> N/A <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>12-10-60</b>   | 9. AGE (In years last birthday)<br>yrs.<br><b>26</b>   | IF UNDER 1 YEAR<br>Months Days<br><b>26 5</b>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>N/A</b>  |                                | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>  |   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |   |
| 13. FATHER'S NAME<br><b>SFC Keith E. Hartwig</b>   |                                |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary E. Hunt</b>   |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>-</b>  |                                | 16. SOCIAL SECURITY NO.<br><b>-</b>  |   | 17. INFORMANT<br>Address<br><b>Father 7311-E Gammons Ft Geo G. Meade, Md.</b>                                  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br><b>774X</b> IMMEDIATE CAUSE (a) <b>Respiratory Distress Syndrome</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost.<br>(b) DUE TO<br>(c)                        |                                |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>26 Hrs 5 Min</b>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Prematurity</b>   |                                |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>  |                                | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>USA Hosp Ft Geo G. Meade, Md.</b> |   |
| 20f. (City or town)<br><b>USA Hosp Ft Geo G. Meade, Md.</b>  |                                | 20g. (County)<br><b>USA Hosp Ft Geo G. Meade, Md.</b>  |   | 20h. (State)<br><b>USA Hosp Ft Geo G. Meade, Md.</b>   |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>10 Dec 1960</b> to <b>11 Dec 1960</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>5A M.</b> from the causes and on the date stated above.  |                                |  |   |  |   |
| 22a. SIGNATURE<br><b>Sherman S. Robinson</b>   |                                |  | 22b. DATE<br><b>11 Dec 60</b>   |  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>SHERMAN S. ROBINSON, Capt., M.C.</b>  |                                |  | 22d. ADDRESS<br><b>USA Hosp Ft Geo G. Meade, Md.</b>  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial Dec. 14, 1960</b>   |                                | 23b. DATE THEREOF<br><b>Dec. 14, 1960</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington Natl</b>  |   |
| 23d. LOCATION (City, town, or county)<br><b>Arlington</b>  |                                | 23e. (State)<br><b>Virginia</b>  |   | 23f. (Country)<br><b>USA</b>   |   |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>DeWitt Canaldan, Laurel, Md</b>   |                                |  | 25a. REC'D BY REGISTRAR<br>DATE <b>DEC 15 '60</b>   |  |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Hunt</b>  |                                |  | 25c. (State)<br><b>USA</b>  |  |   |

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CENTRAL AIR OF DENVER

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
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the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

13401  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13351

|   |  |   |  |  |  |   |  |   |  |
|---|--|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b> ✓                      |  |   |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Crownsville</b>  |  |   |  | c. LENGTH OF STAY IN 1b<br><b>8 yrs.</b><br><b>3mo. 17 days</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b> <b>3 V D 1-4</b> |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Crownsville State Hospital</b>   |  |   |  | d. STREET ADDRESS<br><b>703 N. Mount Street</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                     |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Hawkins</b> Middle Last <b>Addie</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>12</b> Day <b>21</b> Year <b>19 60</b>  |  |   |  |   |  |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>Negro</b>          |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>              |  | 8. DATE OF BIRTH<br><b>1883?</b>  |  |   |  |
| 9. AGE (In years last birthday)<br><b>77?</b> yrs.  |  | IF UNDER 1 YEAR<br>Months Days Hours Min. |  | IF UNDER 24 HRS.<br>Hours Min.   |  |   |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Domestic</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>-----</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>North Carolina</b>  |  |   |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |   |  |  |  |   |  |   |  |
| 13. FATHER'S NAME<br><b>Unknown</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Dollie Jones Davis</b>  |  |   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>Unknown</b>   |  |   |  | 16. SOCIAL SECURITY NO.<br><b>Unknown</b>  |  | 17. INFORMANT<br><b>Hospital Records</b> Address  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br><b>420.1</b> IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Coronary Sclerosis</b><br>DUE TO<br>(c) <b>Arteriosclerotic Cardiovascular Disease</b> |  |   |  |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |  |  |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>-----</b>   |  |   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. ----- p. m. <b>19</b>  |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>-----</b>                                |  |   |  |
| 20f. (City or town)<br><b>-----</b>   |  |   |  | 20g. (County)<br><b>-----</b>  |  | 20h. (State)<br><b>-----</b>  |  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>9/4</b> to <b>12/21</b> 19 <b>60</b> that (I) (we) last saw the deceased alive on <b>12/21</b> 19 <b>60</b> and that death occurred at <b>10:15</b> P. M. from the causes and on the date stated above.  |  |   |  |  |  |   |  |   |  |
| 22a. SIGNATURE<br><b>[Signature]</b>  |  |   |  | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED<br><b>12/22/60</b> |  |   |  |   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>L. Benedict, M. D.</b>   |  |   |  | 22d. ADDRESS<br><b>Crownsville State Hospital, Maryland</b>  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE THEREOF<br><b>12-24-60</b>      |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn Cem.</b>   |  | 23d. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>   |  |   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>[Signature]</b>  |  |   |  | ADDRESS<br><b>578 W. St.</b>   |  | 25a. REC'D BY REGISTRAR<br><b>DEC 27 '60</b>  |  |   |  |
|   |  |   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |   |  |

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TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

13350  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13352

|   |                                  |   |   |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>             |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>7 days</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Anne Arundel General Hospital</b>  |                                  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 4. DATE OF DEATH<br>First <b>Howard</b> Middle <b>M</b> Last <b>HAYS</b>  |                                  | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>13</b> Year <b>19 60</b>   |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>January 22, 1909</b> |
| 9. AGE (In years last birthday)<br><b>51</b> yrs.   |                                  | 10. IF UNDER 1 YEAR<br>Months <b>51</b> Days <b>13</b> Hours <b>19</b> Min. <b>60</b>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Cement Finisher</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |   |
| 13. FATHER'S NAME<br><b>Oscar G. Hays</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Lucinda</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>215 248609</b>  |   |
| 17. INFORMANT<br><b>Family</b>  |                                  | Address<br><b>Albany</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Terminal broncho pneumonia</b><br>DUE TO <b>5811</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Asphyxiated oropharyngeal varices</b><br>DUE TO<br>(c) <b>Cirrhosis of liver</b> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b><br><b>1 week</b><br><b>5-10 years</b>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>ALCOHOLISM</b>  |                                  | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. 19<br>p. m.  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) (his hospital) attended the deceased from <b>Dec. 6, 1960</b> to <b>Dec. 13, 1960</b> , that (I) (we) last saw the deceased alive on <b>Dec. 13, 1960</b> , and that death occurred at <b>12:40 P.M.</b> from the causes and on the date stated above.   |                                  |   |   |
| 22a. SIGNATURE<br><b>Gerald Church</b>  |                                  | 22b. DATE SIGNED<br><b>12/13/60</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Gerald Church</b>  |                                  | 22d. ADDRESS<br><b>121 Cathedral St., Annapolis, Md.</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>12-16-60</b>  |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. John's Cemetery</b>  |                                  | 23d. LOCATION (City, town, or county) (State)<br><b>St. John's, Md.</b>   |   |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert S. Banerico</b>   |                                  | 25a. REC'D BY REGISTRAR<br><b>DATE DEC 19 '60</b>   |   |
| ADDRESS<br><b>Severna Park</b>  |                                  | 25b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hanna</b>  |   |

1850

CERTIFICATE OF DEATH

1850

John A. Smith

John A. Smith

John A. Smith

John A. Smith

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TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  |  |   |   |   |  |   |  |  |  |
|--|--|---|---|---|--|---|--|--|--|
| 13378  |  |   |   |   | 13353  |   |  |  |  |
| CERTIFICATE OF DEATH   |  |   |   |   |  |   |  |  |  |
| Reg. Dist. No.   |  |   |   |   |  |   |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>A.A.</b> <b>MARYLAND</b>   |  |   |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Md.</b> b. COUNTY <b>99</b> |   |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Riviera Beach</b>   |  |   |   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Riviera Beach</b>                         |   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>209 Hilltop Road</b>  |  |   |   |   | d. STREET ADDRESS<br><b>209 Hilltop Road</b>   |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>EDWARD W.</b> Middle <b>HEALY</b> Last  |  |   |   |   | 4. DATE OF DEATH<br><b>12/20/60</b> Month <b>12</b> Day <b>20</b> Year <b>1960</b>   |   |  |  |  |
| 5. SEX<br><b>M</b>   |  | 6. COLOR OR RACE<br><b>W</b>  |   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>9/25/96</b>                                |  | 9. AGE (In years last birthday) <b>64</b> yrs.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Upholsterer</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S.C.G. Ret.</b>                         |   | 11. BIRTHPLACE (State or foreign country)<br><b>Md.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?                                      |  |  |  |
| 13. FATHER'S NAME<br><b>Edward M.</b>  |  |   |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Catherine Smith</b>   |   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>Yes</b>  |  | 16. SOCIAL SECURITY NO.<br>(If yes, give number or date of service)<br><b>WW1</b> |   | INFORMANT<br><b>Family - Same</b>   |  |   | Address  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]<br>PART I. DEATH WAS CAUSED BY:<br><b>163X</b> IMMEDIATE CAUSE (a) <b>Carcinoma Lung</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) DUE TO<br>(c) DUE TO<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>8 months</b>       |  |   |   |   |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                     |   |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>   |  |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)                 |  |  |
| 21. I certify that I attended the deceased from <b>April</b> , 19 <b>60</b> , to <b>Dec. 19</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Dec. 19</b> , 19 <b>60</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br><b>J. Brady Smith</b> M.D. <b>8471 Ft. Smallwood Rd</b> <b>12/20/60</b><br>ACTUAL SIGNATURE<br><b>J. BRADY SMITH</b> <b>Paradise, Md</b><br>PHYSICIAN'S NAME (Type) |  |   |   |   |  |   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>B</b>  |  | 22b. DATE THEREOF<br><b>12/23/60</b>  |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Baltimore</b> |  |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>McCully - 130 E. Fort Avenue</b>  |  |   |   |   | 24a. REC'D BY REGISTRAR<br>DATE <b>DEC 23 '60</b>  |   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b> |  |  |

STATE OF TEXAS  
DEPARTMENT OF HEALTH

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Reg. Dist. No.

13354

|  |                              |   |  |
|--|------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>ANNE ARUNDEL</b><br>MARYLAND  |                              | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Anne Arundel</b>    |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town)<br><b>Glen Burnie</b>  |                              | c. LENGTH OF STAY IN 1b<br><b>60</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>1007 Balto - Annap - Blvd., N.E.</b>  |                              | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First<br><b>JOHN</b><br>Middle<br><b>WADE</b><br>Last<br><b>HENKEL</b>   |                              | 4. DATE OF DEATH<br>Month<br><b>Dec</b><br>Day<br><b>1</b><br>Year<br><b>1960</b>   |  |
| 5. SEX<br><b>M</b>   | 6. COLOR OR RACE<br><b>W</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>7-25-1888</b>   |
| 9. AGE (In years last birthday)<br><b>72</b> yrs.  |                              | IF UNDER 1 YEAR<br>Months<br><b>72</b>  | IF UNDER 24 HRS.<br>Days<br><b>72</b><br>Hours<br><b>72</b><br>Min.<br><b>72</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Engineer (ret.)</b>  |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>B. &amp; O. R.R.</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>   |                              | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>Samuel G. Henkel</b>   |                              | 14. MOTHER'S MAIDEN NAME<br><b>Sarah Wade</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>No</b>   |                              | 16. SOCIAL SECURITY NO.<br><b>705-05-5133</b>   |  |
| 17. INFORMANT<br><b>Mrs. Anna L. Henkel</b>  |                              | Address<br><b>Same As #2</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>420.0</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br><b>Coronary Thrombosis</b><br>(c)<br><b>Coronary artery disease</b><br><b>ARTERIOVASCULAR Heart Disease and Hypertension</b>  |                              | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                              | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY<br>Hour<br><b>19</b><br>a. m.<br>p. m.   |                              | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                              | 20f. (City or town)<br>(County)<br>(State)  |  |
| 21. I certify that I attended the deceased from <b>March</b> , 19 <b>59</b> , to <b>Dec 1</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Nov 30</b> , 19 <b>60</b> , and that death occurred at <b>7:15 A.M.</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state)<br><b>102 B &amp; A Blvd. N.E.</b><br>DATE SIGNED<br><b>12-1-60</b><br>ACTUAL SIGNATURE<br><b>JOSEPH TALER</b><br>M.D.<br>PHYSICIAN'S NAME (Type)<br><b>JOSEPH TALER</b><br><b>Glen Burnie, Md.</b> |                              |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                              | 22b. DATE THEREOF<br><b>5th Dec-1960</b>  |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Western Cemo</b>  |                              | 22d. LOCATION (City, town, or county)<br><b>Balto., Md.</b>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>R.V. Singleton</b>  |                              | 24a. REC'D BY REGISTRAR<br>DATE<br><b>DEC 6 '60</b>   |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kross</b>   |                              |   |  |

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may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13351

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
13355

**CERTIFICATE OF DEATH**

|  |                                  |   |   |   |   |   |   |
|--|----------------------------------|---|---|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> MARYLAND  |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> |   |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>   |                                  |   |   | c. LENGTH OF STAY IN 1b   |   |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION (Dead on arrival)<br><b>Anne Arundel General Hospital</b>   |                                  |   |   | d. STREET ADDRESS<br><b>207 Lockwood St.,</b>   |   |   |   |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |   |   |   |   |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Madeline</b> Middle <b>GROLZ</b> Last <b>HEROLD</b>  |                                  | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>4</b> Year <b>19 60</b>  |   |   |   |   |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>November 9, 1896</b> | 9. AGE (In years last birthday)<br><b>64</b> yrs.   | IF UNDER 1 YEAR<br>Months Days Hours Min. | IF UNDER 24 HRS.<br>Hours Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOME</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>HOUSEWIFE</b>   |   | 11. BIRTHPLACE (State or foreign country)<br><b>New York</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>                                   |   |
| 13. FATHER'S NAME<br><b>CHARLES GROLZ</b>  |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Emily Christy</b>  |   |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)   |                                  | 16. SOCIAL SECURITY NO.<br><b>—</b>   |   | 17. INFORMANT<br><b>Anthony Herold</b>  |   | Address<br><b>#2</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>gen. carcinomatosis c cerebral metastasis</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>carcinoma of breast rt. (resected)</b><br>DUE TO<br>(c) <b>diabetes mellitus</b> |                                  |   |   |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 hrs.</b><br><br><b>18 mos.</b>                           |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |   |   |   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |   |   |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) <b>physician</b> attended the deceased from <b>Apr. 59</b> to <b>Dec. 4, 1960</b> , that (I) <b>(x)</b> last saw the deceased alive on <b>Dec. 3, 1960</b> , and that death occurred at <b>8:40 AM</b> from the causes and on the date stated above.  |                                  |   |   |   |   |   |   |
| 22a. SIGNATURE<br><b>S. Borssuck</b>   |                                  |   |   | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>            |   | 22b. DATE SIGNED<br><b>12/6/60</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Samuel Borssuck</b>   |                                  |   |   | 22d. ADDRESS<br><b>Amos Garrett Blvd., Annapolis, Md.</b>   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>CREMATION</b>  |                                  | 23b. DATE THEREOF<br><b>12-6, 60</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln</b>  |   | 23d. LOCATION (City, town, or county) (State)<br><b>Prince George Co. Md.</b> |   |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>John M. Lytle &amp; Sons Annapolis, Md.</b>   |                                  |   |   | 25a. REC'D BY REGISTRAR<br><b>DEC 8 '60</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles S. Kraus</b>                         |   |

13355

CENTRAL BANK OF CANADA

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13356

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Anne Arundel Co.</u> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Mo.</u> b. COUNTY <u>A. A. Co.</u>                   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shady side</u>  |  | c. LENGTH OF STAY IN lb <u>LIFE</u>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>James</u> First <u>E.</u> Middle <u>Holland</u> Last  |  | 4. DATE OF DEATH<br>Month <u>12</u> Day <u>31</u> Year <u>1960</u>  |  |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>Colored</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>             | 8. DATE OF BIRTH <u>April 2, 1930</u>                              |
| 9. AGE (In years last birthday) <u>30</u> yrs.  | IF UNDER 1 YEAR<br>Months <u>30</u> Days <u>30</u> Hours <u>30</u> Min.  | IF UNDER 24 HRS.<br>Months <u>30</u> Days <u>30</u> Hours <u>30</u> Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pile Driving</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Churchtown, Md</u>   |  |
| 11. BIRTHPLACE (State or foreign country) <u>USA</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>   |  |
| 13. FATHER'S NAME <u>James Edward Holland Sr</u>  |  | 14. MOTHER'S MAIDEN NAME <u>Hilda Brown</u>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>Korean</u>  |  | 16. SOCIAL SECURITY NO. <u>216-24-6309</u>  |  |
| 17. INFORMANT <u>James E Holland Sr</u>   |  | Address <u>Churchtown Md</u>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Drowning</u><br>850X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Sudden</u><br>DUE TO (c)   |  | INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell overboard from own oyster boat</u>                   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. <u>12.31</u> 19 <u>60</u>   | 20d. INJURY OCCURRED<br>While of work <input checked="" type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Chesapeake Bay</u>  | 20f. (City or town) <u>A.A.</u> (County) <u>Md.</u> (State)        |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . |  |   |  |
| ACTUAL SIGNATURE <u>[Signature]</u>   |  | DATE SIGNED <u>12/31/60</u>   |  |
| EXAMINER'S NAME (Type) <u>E. L. [Signature]</u>   |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>   | 22b. DATE THEREOF <u>Jan 4, 1961</u>   | 22c. NAME OF CEMETERY OR CREMATORY <u>Brown Cemetery</u>  | 22d. LOCATION (City, town, or county) <u>Churchtown Md</u> (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>T. A. Hardisty &amp; Son</u>  |  | ADDRESS <u>Galeville, Md</u>  |  |
| 24a. REC'D BY REGISTRAR <u>Jan 9 '61</u>  |  | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>   |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





1  
10-1-60 copy  
2-1-60  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13404  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
13357  
CERTIFICATE OF DEATH

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> MARYLAND  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> ✓                |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Crownsville</b>   |  | c. LENGTH OF STAY IN 1b<br><b>31 years</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Sandy Springs</b>  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Crownsville State Hospital</b>  |  |  |  | d. STREET ADDRESS<br><b>Unknown</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Howard</b> Middle <b>O</b> Last <b>Hopkins</b>   |  |  |  | 4. DATE OF DEATH<br>Month <b>12</b> Day <b>19</b> Year <b>1960</b>  |  |   |  |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>Negro</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>1886</b>   |  |
| 9. AGE (In years last birthday)<br><b>74</b> yrs.  |  | IF UNDER 1 YEAR<br>Months Days Hours Min.  |  | IF UNDER 24 HRS.<br>Hours Min.  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>-----</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>Lewis Hopkins</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Emma Berry</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO.<br><b>Unknown</b>  |  | 17. INFORMANT<br><b>Hospital Records</b>  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>443 X</b> DUE TO <b>Cardiac Failure</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) DUE TO <b>Chronic Brain Syndrome ass. with Hypertensive -</b><br>(c) DUE TO <b>Cardiovascular Disease.</b> |  | INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |  |   |  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>-----</b>                         |  |   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. <b>-----</b> 19<br>p. m. <b>-----</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                            |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>-----</b>  |  | 20f. (City or town) (County) (State)<br><b>-----</b>  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>12/19/60</b> to <b>12/19/60</b> , that (I) (we) last saw the deceased alive on <b>12/19/60</b> , and that death occurred at <b>12:30</b> A.M., from the causes and on the date stated above.  |  |  |  |   |  |   |  |
| 22a. SIGNATURE<br><b>L. Benedict, M. D.</b>  |  | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22b. DATE SIGNED<br><b>12/19/60</b>   |  |   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>L. Benedict, M. D.</b>  |  | 22d. ADDRESS<br><b>Crownsville State Hospital, Maryland</b>  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>12-29-60</b>   |  | 23b. DATE THEREOF<br><b>12-29-60</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>2. of Md.</b>  |  | 23d. LOCATION (City, town, or county) (State)<br><b>Baltimore Md.</b>                             |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>William Reese, Jr. - Anna</b>   |  |  |  | ADDRESS<br><b>-----</b>   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>DEC 30 60</b>  |  |
|  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Howard</b>   |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

# STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

13352

13358

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>             |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>1989 MAIN ST.</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Anne Arundel General Hospital</b>   |                                  | d. STREET ADDRESS<br><b>ANNAPOLIS</b>   |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>SARAH</b> Middle <b>JANE</b> Last <b>HOWERSHELT</b>  |                                  | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>22</b> Year <b>1960</b>  |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>November 15, 1875</b> |
| 9. AGE (In years lost birthday)<br><b>85</b> yrs.  |                                  | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>DOMESTIC</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  |
| 13. FATHER'S NAME<br><b>SAMUAL MONTGOMERY</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>UNKNOWN</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>—</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>—</b>   |  |
| 17. INFORMANT<br><b>MRS THOMAS H. GROSE #2</b>   |                                  | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Obstructive jaundice</b><br><b>155-1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of cystic duct</b> DUE TO<br>(c) <b>Arteriosclerotic cardiovascular disease with congestive failure</b><br>INTERVAL BETWEEN ONSET AND DEATH<br><b>10 da</b><br><b>1 mo.</b> |                                  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Arteriosclerotic cardiovascular disease with congestive failure</b>  |                                  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 14, 1960</b> to <b>Dec. 22, 1960</b> , that (I) (we) last saw the deceased alive on <b>Dec. 22, 1960</b> , and that death occurred at <b>4:30 A.M.</b> from the causes and on the date stated above.   |                                  |   |  |
| 22a. SIGNATURE<br><b>Richard N. Peeler</b> M.D.  |                                  | 22b. DATE<br><b>12/22/60</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Richard N. Peeler</b>   |                                  | 22d. ADDRESS<br><b>121 Cathedral St., Annapolis, Md.</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                                  | 23b. DATE THEREOF<br><b>12-24-1960</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>HILLCREST MEM.</b>  |                                  | 23d. LOCATION (City, town, or county) (State)<br><b>ANNAPOLIS MD.</b>   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>JOHN M. TAYLOR-SOVS</b>   |                                  | 25a. REC'D BY REGISTRAR<br><b>DEC 27 '60</b>  |  |
| ADDRESS<br><b>ANNAPOLIS MD.</b>  |                                  | 25b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Harris</b>   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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13354

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13359

|  |                                  |  |   |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>          |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>3 days</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Anne Arundel General Hospital</b>   |                                  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <del>Rayfield</del> Middle <b>JACKSON</b> Last <b>JACKSON</b>   |                                  | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>7</b> Year <b>19 60</b>   |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>Negro</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>May 16, 1885</b> |
| 9. AGE (In years last birthday)<br><b>75</b>   |                                  | 10. IF UNDER 1 YEAR<br>Months <b>7</b> Days <b>19</b> Hours <b>60</b>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>U.S. Naval Academy - Laborer - retired</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Maryland</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 13. FATHER'S NAME<br><b>Andrew Jackson</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Louise Kelly</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>None</b>   |   |
| 17. INFORMANT<br><b>Irene Williamson-Box 410 Severna Park Md.</b>  |                                  | Address  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Electrolytic Intoxication</b><br><b>561.5</b> DUE TO <b>Bowel Obstruction + Gangrene</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO <b>Strangulated Hernia</b><br>(b) <b>Strangulated Hernia</b><br>(c) <b>Strangulated Hernia</b> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>7</b>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>                                  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |   |
| 21. I certify that (I) (the doctor) attended the deceased from <b>8-2-5-60</b> to <b>12-7-60</b> , that (I) <b>last</b> saw the deceased alive on <b>Dec. 7, 19 60</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.   |                                  |  |   |
| 22a. SIGNATURE<br><b>A. T. Allen</b>   |                                  | 22b. DATE SIGNED<br><b>8:20 A.M.</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Aris T. Allen</b>   |                                  | 22d. ADDRESS<br><b>62 Cathedral St., Annapolis, Md.</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>12-11-60</b>   |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Carpenters Hill</b>   |                                  | 23d. LOCATION (City, town, or county) (State)<br><b>Severna Park- Md.</b>  |   |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>C.E. Hicks III</b>  |                                  | ADDRESS<br><b>Annapolis, Maryland</b>  |   |
| 25a. REC'D BY REGISTRAR<br>DATE <b>DEC 14 '60</b>  |                                  | 25b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Thomas</b>  |   |

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 13355 CERTIFICATE OF DEATH

13360

Reg. Dist. No.

|  |   |   |  |  |   |  |  |
|--|---|---|--|--|---|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Anne Arundel</u> <span style="float: right;">MARYLAND</span>  |   |   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Anne Arundel</u></span>    |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Annapolis</u>   |   |   | c. LENGTH OF STAY IN 1b<br><u>10</u>   |  |   |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>USNH, Annapolis, Md.</u>  |   |   |  | d. STREET ADDRESS<br><u>11 Maryland Avenue</u>   |   |  |  |
| <b>3. NAME OF DECEASED</b> (Type or print)<br><div style="display: flex; justify-content: space-between;"> <span>First <u>Horace</u></span> <span>Middle <u>Homer</u></span> <span>Last <u>Jalbert</u></span> </div>   |   |   |  | <b>4. DATE OF DEATH</b><br><div style="display: flex; justify-content: space-between;"> <span>Month <u>December</u></span> <span>Day <u>15th</u></span> <span>Year <u>1960</u></span> </div> |   |  |  |
| 5. SEX<br><u>M</u>   | 6. COLOR OR RACE<br><u>White</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>7/19/1891</u>   |  | 9. AGE (In years last birthday)<br><u>69</u> yrs. |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>USN - Retired</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Rear Admiral USN</u>  |  | 11. BIRTHPLACE (State or foreign country)<br><u>Rhode Island</u>   |   |  |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |   |   |  | 13. FATHER'S NAME<br><u>Joseph J. Jalbert</u>  |   |  |  |
| 14. MOTHER'S MAIDEN NAME<br><u>Josephine Pinault</u>   |   |   |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>yes</u>   |   |  |  |
| 16. SOCIAL SECURITY NO.<br><u>WW1 and 11</u>   |   |   |  | 17. INFORMANT<br><u>Wife - 11 Maryland Avenue, Annapolis, Md</u>   |   |  |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br><div style="border: 1px solid black; padding: 5px;">           PART I. DEATH WAS CAUSED BY:<br/>           IMMEDIATE CAUSE (a) <u>Septicemia</u><br/>           DUE TO<br/>           Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Gangrene left thigh with infection</u><br/>           DUE TO (c) <u>Generalized Arteriosclerosis Obliterans</u> </div> |   |   |  |  |   |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |   |   |  |  |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |  |   |  |  |
| 20c. TIME OF INJURY<br>Hour <u>19</u> a. m. <u>19</u> p. m.  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town)  | (County)   | (State)   |  |  |
| 21. I certify that I attended the deceased from <u>11/7</u> , 19 <u>60</u> , to <u>12/15</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>12/15</u> , 19 <u>60</u> , and that death occurred at <u>11:15</u> AM, from the causes and on the date stated above.<br><div style="display: flex; justify-content: space-between;"> <span>ADDRESS (Street, city or town, state)</span> <span>DATE SIGNED</span> </div>   |   |   |  |  |   |  |  |
| ACTUAL SIGNATURE <u>R. G. Williams</u>   |   |   | M.D. <u>USNH, ANNAPOLIS, MARYLAND</u>  |  |   |  |  |
| PHYSICIAN'S NAME (Type) <u>R. G. WILLIAMS, JR., CDR MC USN</u>   |   |   |  |  |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |   | 22b. DATE THEREOF<br><u>Dec-19-1960</u>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Naval Academy Cem</u>   |   |  |  |
| 22d. LOCATION (City, town, or county)<br><u>Annapolis</u>  |   | (State)<br><u>Md</u>  |  | 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>John M. Saylor</u>  |   |  |  |
| ADDRESS<br><u>Annapolis, Md</u>  |   | 24a. REC'D BY REGISTRAR<br><u>DEC 19 1960</u>   |  | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Krawe</u>   |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

# CERTIFICATE OF DEATH

Page One of Two

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| <p>1. NAME OF DECEASED<br/>[REDACTED]</p>      |  | <p>2. SEX<br/>[REDACTED]</p>                     |  | <p>3. AGE<br/>[REDACTED]</p>                     |  |
| <p>4. DATE OF BIRTH<br/>[REDACTED]</p>         |  | <p>5. PLACE OF BIRTH<br/>[REDACTED]</p>          |  | <p>6. RACE<br/>[REDACTED]</p>                    |  |
| <p>7. OCCUPATION<br/>[REDACTED]</p>            |  | <p>8. MARITAL STATUS<br/>[REDACTED]</p>          |  | <p>9. EDUCATION<br/>[REDACTED]</p>               |  |
| <p>10. DATE OF DEATH<br/>[REDACTED]</p>        |  | <p>11. TIME OF DEATH<br/>[REDACTED]</p>          |  | <p>12. PLACE OF DEATH<br/>[REDACTED]</p>         |  |
| <p>13. CAUSE OF DEATH<br/>[REDACTED]</p>       |  | <p>14. MANNER OF DEATH<br/>[REDACTED]</p>        |  | <p>15. SIGNATURE OF DECEASED<br/>[REDACTED]</p>  |  |
| <p>16. SIGNATURE OF WITNESS<br/>[REDACTED]</p> |  | <p>17. SIGNATURE OF PHYSICIAN<br/>[REDACTED]</p> |  | <p>18. SIGNATURE OF CORONER<br/>[REDACTED]</p>   |  |
| <p>19. SIGNATURE OF JUDGE<br/>[REDACTED]</p>   |  | <p>20. SIGNATURE OF CLERK<br/>[REDACTED]</p>     |  | <p>21. SIGNATURE OF REGISTRAR<br/>[REDACTED]</p> |  |

THIS CERTIFICATE IS VALID ONLY WHEN SIGNED BY THE OFFICIALS OF THE DEPARTMENT OF HEALTH.

TO THE PUBLIC: This certificate is a legal document and should be kept in a safe place. It is used to prove the date and cause of death. If you have any questions, please contact the Department of Health.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

13356  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13361

|   |                              |   |                                   |
|---|------------------------------|---|-----------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>A. A.</u> MARYLAND  |                              | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>A. A.</u>  |                                   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>   |                              | c. LENGTH OF STAY IN 1b <u>10</u>   |                                   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>74 Pleasant Street</u>  |                              | d. STREET ADDRESS <u>74 Pleasant St.</u>  |                                   |
| 3. NAME OF DECEASED<br>(Type or print) <u>Elizabeth</u> First <u>Johnson</u> Middle Last  |                              | 4. DATE OF DEATH<br>Month <u>12</u> Day <u>31</u> Year <u>1960</u>  |                                   |
| 5. SEX <u>Female</u>  | 6. COLOR OR RACE <u>Col.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH <u>5-25-1909</u> |
| 9. AGE (In years last birthday) <u>51</u> yrs.  |                              | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>   |                                   |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u>   |                              | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |                                   |
| 13. FATHER'S NAME <u>Charles H. Green</u>   |                              | 14. MOTHER'S MAIDEN NAME <u>Naomi Johnson</u>   |                                   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>  |                              | 16. SOCIAL SECURITY NO. <u>Naomi Kirby</u>  |                                   |
| 17. INFORMANT Address <u>74 Pleasant St.</u>  |                              | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Enteric salmonella typhosa</u><br><u>443X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiac valve disease</u> DUE TO<br>(c) <u>5 months</u> |                                   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                              | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>  |                              | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                              | 20f. (City or town) (County) (State)  |                                   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>8/11</u> 19 <u>60</u> to <u>1/4/61</u> , that (I) (we) last saw the deceased alive on <u>12/31</u> 19 <u>60</u> , and that death occurred at <u>10:00</u> M, from the causes and on the date stated above. |                              |   |                                   |
| 22a. SIGNATURE <u>R. L. Richardson</u>  |                              | 22b. DATE SIGNED <u>1/4/61</u>  |                                   |
| 22c. PHYSICIAN'S NAME (Type) <u>R. L. RICHARDSON M.D.</u>   |                              | 22d. ADDRESS <u>110 - clay street Annapolis Md.</u>   |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |                              | 23b. DATE THEREOF <u>1-5-1961</u>   |                                   |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>   |                              | 23d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>  |                                   |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese</u>   |                              | 25a. REC'D BY REGISTRAR <u>Jan 9 '61</u>  |                                   |
| ADDRESS <u>Annapolis Md.</u>  |                              | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Travis</u>  |                                   |

TO HOSPITAL  
may be  
TO F

VS A15 (L)  
15M 10/5

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours  
by the hospital or attending physician.  
NOTOR: After this certificate has been signed by the attending physician and completely filled in by  
be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 c

13357

Item 11 Film G276 12-16-60 et

CERTIFICATE OF DEATH

13362

Reg. Dist. No.

|   |                                  |   |  |   |  |  |  |
|---|----------------------------------|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> MARYLAND   |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>  |                                  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>138 Lafayette Ave.</b>   |                                  |   |  | d. STREET ADDRESS<br><b>138 Lafayette Ave.</b>  |  |  |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |   |  |   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>HARRY</b> Middle <b>A</b> Last <b>KLAWANS</b>   |                                  |   |  | 4. DATE OF DEATH<br>Month <b>DECEMBER</b> Day <b>6</b> Year <b>1960</b>   |  |  |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>April 4, 1890</b> | 9. AGE (In years last birthday)<br><b>70</b> yrs.   | IF UNDER 1 YEAR<br>Months <b>70</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b> | IF UNDER 24 HRS.<br>Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Prop.</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Retail Dress Shop</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Maryland</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                     |  |
| 13. FATHER'S NAME<br><b>David Klawansky</b>   |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Lena (Unknown)</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>218 32 2074</b>   |  | 17. INFORMANT<br><b>Mrs Fannie Klawans- Wife- Same as # 2</b>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Generalized Arteriosclerosis</b><br>DUE TO<br>(c) <b>Diabetes M.</b>                             |                                  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>W O A</b><br><b>1 yr.</b>  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Diabetes M.</b>  |                                  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>12-6-60</b> , 19 <b>60</b> , to <b>12-7-60</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>12-7-60</b> , 19 <b>60</b> , and that death occurred at <b>3:30 P.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Annapolis, Maryland</b> DATE SIGNED <b>12-7-60</b> |                                  |   |  |   |  |  |  |
| ACTUAL SIGNATURE <b>Frank Shipley</b> M.D.  |                                  |   |  | DATE SIGNED <b>12-7-60</b>  |  |  |  |
| PHYSICIAN'S NAME (Type) <b>Frank Shipley M.D.</b>   |                                  |   |  | ADDRESS (Street, city or town, state) <b>Annapolis, Maryland</b>  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>Dec. 8, 1960</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Hebrew Friendship Cemetery</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>    |  |
| 23. BURIAL DIRECTOR'S SIGNATURE<br><b>Hopping</b>   |                                  |   |  | 24a. REC'D BY REGISTRAR<br><b>DEC 9 '60</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Charles S. ...</b>                            |  |
| ADDRESS<br><b>Annapolis, Maryland</b>   |                                  |   |  |   |  |  |  |

MEDICAL CERTIFICATION

page 3 should be retained by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible] SEX: [illegible] AGE: [illegible]

DATE OF BIRTH: [illegible] PLACE OF BIRTH: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

DATE OF BURIAL: [illegible] PLACE OF BURIAL: [illegible]

SIGNATURE OF DECEASED: [illegible]

SIGNATURE OF WITNESSES: [illegible]

SIGNATURE OF MINISTER: [illegible]

DATE OF SIGNATURE: [illegible]

PLACE OF SIGNATURE: [illegible]

NAME OF MINISTER: [illegible]

DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

DATE OF BURIAL: [illegible]

PLACE OF BURIAL: [illegible]

SIGNATURE OF DECEASED: [illegible]

SIGNATURE OF WITNESSES: [illegible]

SIGNATURE OF MINISTER: [illegible]

DATE OF SIGNATURE: [illegible]

PLACE OF SIGNATURE: [illegible]

NAME OF MINISTER: [illegible]



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 13405

## CERTIFICATE OF DEATH

## 13363

Reg. Dist. No.

|   |  |  |   |  |  |  |  |
|---|--|--|---|--|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>A.A.</u> <span style="float: right;">MARYLAND</span><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>BROOKLYN PK</u><br>c. LENGTH OF STAY IN 1b<br><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>5 W. 324 Ave.</u>                        |  |  |   | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MD</u> <span style="float: right;">b. COUNTY <u>A.A.</u></span><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>50 Brooklyn</u><br>d. STREET ADDRESS<br><u>15 W. 324 Ave</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print)<br>First <u>JOHN</u> Middle <u>KREIG</u> Last <u>KREIG</u>  |  |  | <b>4. DATE OF DEATH</b><br>Month <u>12</u> Day <u>27</u> Year <u>1960</u> |  |  |  |  |
| <b>5. SEX</b><br><u>M</u>   | <b>6. COLOR OR RACE</b><br><u>W</u>  | <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | <b>8. DATE OF BIRTH</b><br><u>6-24-1879</u>                               | <b>9. AGE</b> (In years last birthday) <u>81</u> yrs.  | <b>IF UNDER 1 YEAR</b><br>Months <u>2</u> Days <u>1</u> Hours <u>0</u> Min. <u>0</u> |  |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>Genl. Eng.</u>   |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><u>Hudson</u>  |   | <b>11. BIRTHPLACE</b> (State or foreign country)<br><u>MARYLAND</u>  |  |  |  |
| <b>13. FATHER'S NAME</b><br><u>UNK</u>  |  |  | <b>14. MOTHER'S MAIDEN NAME</b><br><u>UNK</u>                             |  |  |  |  |
| <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b><br>(Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)   |  | <b>16. SOCIAL SECURITY NO.</b><br><u>—</u>   |   | <b>INFORMANT</b><br><u>FAMILY</u> Address <u>Same</u>  |  |  |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of lung, metastatic</u><br>DUE TO <u>Carcinoma pancreas</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>—</u><br>DUE TO <u>—</u><br>(c) <u>—</u> |  |  |   |  | <b>INTERVAL BETWEEN ONSET AND DEATH</b><br><u>2 months</u><br><u>1 year</u>          |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>  |  |  |   |  |  |  |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)  |   |  |  |  |  |
| <b>20c. TIME OF INJURY</b><br>Month, Day, Year<br>Hour a. m. <u>19</u><br>p. m. <u>—</u>  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)  | <b>20f. (City or town)</b>  | (County)   | (State)  |  |  |
| <b>21. I certify that I attended the deceased from</b> <u>12/16</u> , 19 <u>50</u> , to <u>12/27</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>12/27</u> , 19 <u>60</u> , and that death occurred at <u>10:00</u> A.M. from the causes and on the date stated above.  |  |  |   |  |  |  |  |
| <b>ACTUAL SIGNATURE</b><br><u>Benjamin Berdann</u>  |  | <b>ADDRESS</b> (Street, city or town, state)<br><u>5010 A Ritchie Hwy</u>  |   | <b>DATE SIGNED</b><br><u>12/28/60</u>  |  |  |  |
| <b>PHYSICIAN'S NAME (Type)</b><br><u>BENJAMIN BERDANN</u>   |  |  |   |  |  |  |  |
| <b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br><u>B</u>  | <b>22b. DATE THEREOF</b><br><u>12-30-60</u>  | <b>22c. NAME OF CEMETERY OR CREMATORY</b><br><u>Cedar Hill Cem.</u>  | <b>22d. LOCATION</b> (City, town, or county)<br><u>Brooklyn</u>           | (State)<br><u>MD.</u>  |  |  |  |
| <b>23. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>McCully Funeral Hse.</u>  |  |  | <b>ADDRESS</b><br><u>1301 E. Fort Ave.</u>                                |  |  |  |  |
| <b>24a. REC'D BY REGISTRAR</b><br>DATE <u>JAN 3 '61</u>   |  | <b>24b. REGISTRAR'S SIGNATURE</b><br><u>Charles E. Hanna</u>   |   |  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13303

13405

13405

1

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

13364

Reg. Dist. No.

13406

|  |  |   |   |   |   |   |  |  |
|--|--|---|---|---|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>   |  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)<br>a. STATE <b>Md.</b> b. COUNTY <b>A.A. Co.</b>                      |   |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Pasadena</b>  |  |   | c. LENGTH OF STAY IN 1b                             |   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>X Pasadena</b> |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Rt. 9 - D.O.R. ANNE ARUNDEL GEN.</b>  |  |   |   | d. STREET ADDRESS<br><b>1 Rt. 9</b>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>     |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>JOHN</b> Middle <b>CHARLES</b> Last <b>KRISS</b>   |  |   |   | 4. DATE OF DEATH<br>Month <b>Dec.</b> Day <b>5</b> Year <b>19 60</b>  |   |   |  |  |
| 5. SEX<br><b>M</b>   |  | 6. COLOR OR RACE<br><b>W</b>  |   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><b>May 25 1890</b>  |  |  |
| 9. AGE (In years last birthday)<br><b>70 yrs.</b>  |  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |   | IF UNDER 24 HRS.<br>Hours Min.  |   |   |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>  |  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Printer</b> |   | 11. BIRTHPLACE (State or foreign country)<br><b>Md.</b> |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> |  |
| 13. FATHER'S NAME<br><b>Charles Kriss</b>  |  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Beatrice ?</b>   |   |   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO.   |   | 17. INFORMANT<br><b>Family</b>  |   | Address<br><b>Above</b>   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br><div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY:<br/>IMMEDIATE CAUSE (a) <b>434-4</b> <b>Cardiac disease</b><br/> DUE TO<br/> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <br/> DUE TO (c) <br/> </p> </div> <div style="width: 35%;"> <p>INTERVAL BETWEEN ONSET AND DEATH<br/><b>1 week</b></p> </div> </div> |  |   |   |   |   |   |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |   |   |   |   |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |   |   |   |   |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)  |  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .   |  |   |   |   |   |   |  |  |
| ACTUAL SIGNATURE <b>E. Linhardt</b>  |  |   |   | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   | DATE SIGNED <b>12-5-60</b>  |  |  |
| EXAMINER'S NAME (Type) <b>E. Linhardt</b>  |  |   |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |   |   |  |  |
|  |  |   |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |   |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>12/9/60</b>   |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Cem.</b>  |   | 22d. LOCATION (City, town, or county) (State)<br><b>Glen Burnie Md.</b>                               |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>SEVERNA PARK FUNERAL HOME</b>   |  |   |   | ADDRESS <b>Robert S. Barranco</b>   |   | 24a. REC'D BY REGISTRAR<br><b>DEC 8 '60</b>   |  |  |
|  |  |   |   | 24b. REGISTRAR'S SIGNATURE<br><b>Gordon L. Kline</b>  |   |   |  |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

13303

STATEMENT OF HEALTH - BATHING IN  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13408

|                  |  |     |  |     |  |      |  |          |  |          |  |           |  |            |  |           |  |               |  |               |  |                |  |                |  |                 |  |                       |  |                     |  |                      |  |                       |  |                       |  |                      |  |                                 |  |                       |  |                   |  |                          |  |      |  |      |  |      |  |      |  |      |  |      |  |      |  |      |  |      |  |      |  |      |  |      |  |      |  |      |  |      |  |      |  |      |  |      |  |      |  |      |  |      |  |      |  |      |  |      |  |      |  |      |  |      |  |      |  |      |  |      |  |      |  |      |  |      |  |      |  |      |  |      |  |      |  |      |  |      |  |      |  |      |  |      |  |      |  |      |  |      |  |      |  |      |  |      |  |      |  |      |  |  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| NAME OF DECEASED |  | AGE |  | SEX |  | RACE |  | RELIGION |  | MARRIAGE |  | EDUCATION |  | OCCUPATION |  | RESIDENCE |  | DATE OF DEATH |  | TIME OF DEATH |  | PLACE OF DEATH |  | CAUSE OF DEATH |  | MANNER OF DEATH |  | SIGNATURE OF EXAMINER |  | DATE OF EXAMINATION |  | PLACE OF EXAMINATION |  | OFFICE OF EXAMINATION |  | COUNTY OF EXAMINATION |  | STATE OF EXAMINATION |  | FEDERAL BUREAU OF INVESTIGATION |  | DEPARTMENT OF JUSTICE |  | WASHINGTON, D. C. |  | UNITED STATES OF AMERICA |  | 1900 |  | 1901 |  | 1902 |  | 1903 |  | 1904 |  | 1905 |  | 1906 |  | 1907 |  | 1908 |  | 1909 |  | 1910 |  | 1911 |  | 1912 |  | 1913 |  | 1914 |  | 1915 |  | 1916 |  | 1917 |  | 1918 |  | 1919 |  | 1920 |  | 1921 |  | 1922 |  | 1923 |  | 1924 |  | 1925 |  | 1926 |  | 1927 |  | 1928 |  | 1929 |  | 1930 |  | 1931 |  | 1932 |  | 1933 |  | 1934 |  | 1935 |  | 1936 |  | 1937 |  | 1938 |  | 1939 |  | 1940 |  | 1941 |  | 1942 |  | 1943 |  | 1944 |  | 1945 |  | 1946 |  | 1947 |  | 1948 |  | 1949 |  | 1950 |  | 1951 |  | 1952 |  | 1953 |  | 1954 |  | 1955 |  | 1956 |  | 1957 |  | 1958 |  | 1959 |  | 1960 |  | 1961 |  | 1962 |  | 1963 |  | 1964 |  | 1965 |  | 1966 |  | 1967 |  | 1968 |  | 1969 |  | 1970 |  | 1971 |  | 1972 |  | 1973 |  | 1974 |  | 1975 |  | 1976 |  | 1977 |  | 1978 |  | 1979 |  | 1980 |  | 1981 |  | 1982 |  | 1983 |  | 1984 |  | 1985 |  | 1986 |  | 1987 |  | 1988 |  | 1989 |  | 1990 |  | 1991 |  | 1992 |  | 1993 |  | 1994 |  | 1995 |  | 1996 |  | 1997 |  | 1998 |  | 1999 |  | 2000 |  | 2001 |  | 2002 |  | 2003 |  | 2004 |  | 2005 |  | 2006 |  | 2007 |  | 2008 |  | 2009 |  | 2010 |  | 2011 |  | 2012 |  | 2013 |  | 2014 |  | 2015 |  | 2016 |  | 2017 |  | 2018 |  | 2019 |  | 2020 |  | 2021 |  | 2022 |  | 2023 |  | 2024 |  | 2025 |  | 2026 |  | 2027 |  | 2028 |  | 2029 |  | 2030 |  | 2031 |  | 2032 |  | 2033 |  | 2034 |  | 2035 |  | 2036 |  | 2037 |  | 2038 |  | 2039 |  | 2040 |  | 2041 |  | 2042 |  | 2043 |  | 2044 |  | 2045 |  | 2046 |  | 2047 |  | 2048 |  | 2049 |  | 2050 |  | 2051 |  | 2052 |  | 2053 |  | 2054 |  | 2055 |  | 2056 |  | 2057 |  | 2058 |  | 2059 |  | 2060 |  | 2061 |  | 2062 |  | 2063 |  | 2064 |  | 2065 |  | 2066 |  | 2067 |  | 2068 |  | 2069 |  | 2070 |  | 2071 |  | 2072 |  | 2073 |  | 2074 |  | 2075 |  | 2076 |  | 2077 |  | 2078 |  | 2079 |  | 2080 |  | 2081 |  | 2082 |  | 2083 |  | 2084 |  | 2085 |  | 2086 |  | 2087 |  | 2088 |  | 2089 |  | 2090 |  | 2091 |  | 2092 |  | 2093 |  | 2094 |  | 2095 |  | 2096 |  | 2097 |  | 2098 |  | 2099 |  | 2100 |  | 2101 |  | 2102 |  | 2103 |  | 2104 |  | 2105 |  | 2106 |  | 2107 |  | 2108 |  | 2109 |  | 2110 |  | 2111 |  | 2112 |  | 2113 |  | 2114 |  | 2115 |  | 2116 |  | 2117 |  | 2118 |  | 2119 |  | 2120 |  | 2121 |  | 2122 |  | 2123 |  | 2124 |  | 2125 |  | 2126 |  | 2127 |  | 2128 |  | 2129 |  | 2130 |  | 2131 |  | 2132 |  | 2133 |  | 2134 |  | 2135 |  | 2136 |  | 2137 |  | 2138 |  | 2139 |  | 2140 |  | 2141 |  | 2142 |  | 2143 |  | 2144 |  | 2145 |  | 2146 |  | 2147 |  | 2148 |  | 2149 |  | 2150 |  | 2151 |  | 2152 |  | 2153 |  | 2154 |  | 2155 |  | 2156 |  | 2157 |  | 2158 |  | 2159 |  | 2160 |  | 2161 |  | 2162 |  | 2163 |  | 2164 |  | 2165 |  | 2166 |  | 2167 |  | 2168 |  | 2169 |  | 2170 |  | 2171 |  | 2172 |  | 2173 |  | 2174 |  | 2175 |  | 2176 |  | 2177 |  | 2178 |  | 2179 |  | 2180 |  | 2181 |  | 2182 |  | 2183 |  | 2184 |  | 2185 |  | 2186 |  | 2187 |  | 2188 |  | 2189 |  | 2190 |  | 2191 |  | 2192 |  | 2193 |  | 2194 |  | 2195 |  | 2196 |  | 2197 |  | 2198 |  | 2199 |  | 2200 |  | 2201 |  | 2202 |  | 2203 |  | 2204 |  | 2205 |  | 2206 |  | 2207 |  | 2208 |  | 2209 |  | 2210 |  | 2211 |  | 2212 |  | 2213 |  | 2214 |  | 2215 |  | 2216 |  | 2217 |  | 2218 |  | 2219 |  | 2220 |  | 2221 |  | 2222 |  | 2223 |  | 2224 |  | 2225 |  | 2226 |  | 2227 |  | 2228 |  | 2229 |  | 2230 |  | 2231 |  | 2232 |  | 2233 |  | 2234 |  | 2235 |  | 2236 |  | 2237 |  | 2238 |  | 2239 |  | 2240 |  | 2241 |  | 2242 |  | 2243 |  | 2244 |  | 2245 |  | 2246 |  | 2247 |  | 2248 |  | 2249 |  | 2250 |  | 2251 |  | 2252 |  | 2253 |  | 2254 |  | 2255 |  | 2256 |  | 2257 |  | 2258 |  | 2259 |  | 2260 |  | 2261 |  | 2262 |  | 2263 |  | 2264 |  | 2265 |  | 2266 |  | 2267 |  | 2268 |  | 2269 |  | 2270 |  | 2271 |  | 2272 |  | 2273 |  | 2274 |  | 2275 |  | 2276 |  | 2277 |  | 2278 |  | 2279 |  | 2280 |  | 2281 |  | 2282 |  | 2283 |  | 2284 |  | 2285 |  | 2286 |  | 2287 |  | 2288 |  | 2289 |  | 2290 |  | 2291 |  | 2292 |  | 2293 |  | 2294 |  | 2295 |  | 2296 |  | 2297 |  | 2298 |  | 2299 |  | 2300 |  | 2301 |  | 2302 |  | 2303 |  | 2304 |  | 2305 |  | 2306 |  | 2307 |  | 2308 |  | 2309 |  | 2310 |  | 2311 |  | 2312 |  | 2313 |  | 2314 |  | 2315 |  | 2316 |  | 2317 |  | 2318 |  | 2319 |  | 2320 |  | 2321 |  | 2322 |  | 2323 |  | 2324 |  | 2325 |  | 2326 |  | 2327 |  | 2328 |  | 2329 |  | 2330 |  | 2331 |  | 2332 |  | 2333 |  | 2334 |  | 2335 |  | 2336 |  | 2337 |  | 2338 |  | 2339 |  | 2340 |  | 2341 |  | 2342 |  | 2343 |  | 2344 |  | 2345 |  | 2346 |  | 2347 |  | 2348 |  | 2349 |  | 2350 |  | 2351 |  | 2352 |  | 2353 |  | 2354 |  | 2355 |  | 2356 |  | 2357 |  | 2358 |  | 2359 |  | 2360 |  | 2361 |  | 2362 |  | 2363 |  | 2364 |  | 2365 |  | 2366 |  | 2367 |  | 2368 |  | 2369 |  | 2370 |  | 2371 |  | 2372 |  | 2373 |  | 2374 |  | 2375 |  | 2376 |  | 2377 |  | 2378 |  | 2379 |  | 2380 |  | 2381 |  | 2382 |  | 2383 |  | 2384 |  | 2385 |  | 2386 |  | 2387 |  | 2388 |  | 2389 |  | 2390 |  | 2391 |  | 2392 |  | 2393 |  | 2394 |  | 2395 |  | 2396 |  | 2397 |  | 2398 |  | 2399 |  | 2400 |  | 2401 |  | 2402 |  | 2403 |  | 2404 |  | 2405 |  | 2406 |  | 2407 |  | 2408 |  | 2409 |  | 2410 |  | 2411 |  | 2412 |  | 2413 |  | 2414 |  | 2415 |  | 2416 |  | 2417 |  | 2418 |  | 2419 |  | 2420 |  | 2421 |  | 2422 |  | 2423 |  | 2424 |  | 2425 |  | 2426 |  | 2427 |  | 2428 |  | 2429 |  | 2430 |  | 2431 |  | 2432 |  | 2433 |  | 2434 |  | 2435 |  | 2436 |  | 2437 |  | 2438 |  | 2439 |  | 2440 |  | 2441 |  | 2442 |  | 2443 |  | 2444 |  | 2445 |  | 2446 |  | 2447 |  | 2448 |  | 2449 |  | 2450 |  | 2451 |  | 2452 |  | 2453 |  | 2454 |  | 2455 |  | 2456 |  | 2457 |  | 2458 |  | 2459 |  | 2460 |  | 2461 |  | 2462 |  | 2463 |  | 2464 |  | 2465 |  | 2466 |  | 2467 |  | 2468 |  | 2469 |  | 2470 |  | 2471 |  | 2472 |  | 2473 |  | 2474 |  | 2475 |  | 2476 |  | 2477 |  | 2478 |  | 2479 |  | 2480 |  | 2481 |  | 2482 |  | 2483 |  | 2484 |  | 2485 |  | 2486 |  | 2487 |  | 2488 |  | 2489 |  | 2490 |  | 2491 |  | 2492 |  | 2493 |  | 2494 |  | 2495 |  | 2496 |  | 2497 |  | 2498 |  | 2499 |  | 2500 |  | 2501 |  | 2502 |  | 2503 |  | 2504 |  | 2505 |  | 2506 |  | 2507 |  | 2508 |  | 2509 |  | 2510 |  | 2511 |  | 2512 |  | 2513 |  | 2514 |  | 2515 |  | 2516 |  | 2517 |  | 2518 |  | 2519 |  | 2520 |  | 2521 |  | 2522 |  | 2523 |  | 2524 |  | 2525 |  | 2526 |  | 2527 |  | 2528 |  | 2529 |  | 2530 |  | 2531 |  | 2532 |  | 2533 |  | 2534 |  | 2535 |  | 2536 |  | 2537 |  | 2538 |  | 2539 |  | 2540 |  | 2541 |  | 2542 |  | 2543 |  | 2544 |  | 2545 |  | 2546 |  | 2547 |  | 2548 |  | 2549 |  | 2550 |  | 2551 |  | 2552 |  | 2553 |  | 2554 |  | 2555 |  | 2556 |  | 2557 |  | 2558 |  | 2559 |  | 2560 |  | 2561 |  | 2562 |  | 2563 |  | 2564 |  | 2565 |  | 2566 |  | 2567 |  | 2568 |  | 2569 |  | 2570 |  | 2571 |  | 2572 |  | 2573 |  | 2574 |  | 2575 |  | 2576 |  | 2577 |  | 2578 |  | 2579 |  | 2580 |  | 2581 |  | 2582 |  | 2583 |  | 2584 |  | 2585 |  | 2586 |  | 2587 |  | 2588 |  | 2589 |  | 2590 |  | 2591 |  | 2592 |  | 2593 |  | 2594 |  | 2595 |  | 2596 |  | 2597 |  | 2598 |  | 2599 |  | 2600 |  | 2601 |  | 2602 |  | 2603 |  | 2604 |  | 2605 |  | 2606 |  | 2607 |  | 2608 |  | 2609 |  | 2610 |  | 2611 |  | 2612 |  | 2613 |  | 2614 |  | 2615 |  | 2616 |  | 2617 |  | 2618 |  | 2619 |  | 2620 |  | 2621 |  | 2622 |  | 2623 |  | 2624 |  | 2625 |  | 2626 |  | 2627 |  | 2628 |  | 2629 |  | 2630 |  | 2631 |  | 2632 |  | 2633 |  | 2634 |  | 2635 |  | 2636 |  | 2637 |  | 2638 |  | 2639 |  | 2640 |  | 2641 |  | 2642 |  | 2643 |  | 2644 |  | 2645 |  | 2646 |  | 2647 |  | 2648 |  | 2649 |  | 2650 |  | 2651 |  | 2652 |  | 2653 |  | 2654 |  | 2655 |  | 2656 |  | 2657 |  | 2658 |  | 2659 |  | 2660 |  | 2661 |  | 2662 |  | 2663 |  | 2664 |  | 2665 |  | 2666 |  | 2667 |  | 2668 |  | 2669 |  | 2670 |  | 2671 |  | 2672 |  | 2673 |  | 2674 |  | 2675 |  | 2676 |  | 2677 |  | 2678 |  | 2679 |  | 2680 |  | 2681 |  | 2682 |  | 2683 |  | 2684 |  | 2685 |  | 2686 |  | 2687 |  | 2688 |  | 2689 |  | 2690 |  | 2691 |  | 2692 |  | 2693 |  | 2694 |  | 2695 |  | 2696 |  | 2697 |  | 2698 |  | 2699 |  | 2700 |  | 2701 |  | 2702 |  | 2703 |  | 2704 |  | 2705 |  | 2706 |  | 2707 |  | 2708 |  | 2709 |  | 2710 |  | 2711 |  | 2712 |  | 2713 |  | 2714 |  | 2715 |  | 2716 |  | 2717 |  | 2718 |  | 2719 |  | 2720 |  | 2721 |  | 2722 |  | 2723 |  | 2724 |  | 2725 |  | 2726 |  | 2727 |  | 2728 |  | 2729 |  | 2730 |  | 2731 |  | 2732 |  | 2733 |  | 2734 |  | 2735 |  | 2736 |  | 2737 |  | 2738 |  | 2739 |  | 2740 |  | 2741 |  | 2742 |  | 2743 |  | 2744 |  | 2745 |  | 2746 |  | 2747 |  | 2748 |  | 2749 |  | 2750 |  | 2751 |  | 2752 |  | 2753 |  | 2754 |  | 2755 |  | 2756 |  | 2757 |  | 2758 |  | 2759 |  | 2760 |  | 2761 |  | 2762 |  | 2763 |  | 2764 |  | 2765 |  | 2766 |  | 2767 |  | 2768 |  | 2769 |  | 2770 |  | 2771 |  | 2772 |  | 2773 |  | 2774 |  | 2775 |  | 2776 |  | 2777 |  | 2778 |  | 2779 |  | 2780 |  | 2781 |  | 2782 |  | 2783 |  | 2784 |  | 2785 |  | 2786 |  | 2787 |  | 2788 |  | 2789 |  | 2790 |  | 2791 |  | 2792 |  | 2793 |  | 2794 |  | 2795 |  | 2796 |  | 2797 |  | 2798 |  | 2799 |  | 2800 |  | 2801 |  | 2802 |  | 2803 |  | 2804 |  | 2805 |  | 2806 |  | 2807 |  | 2808 |  | 2809 |  | 2810 |  | 2811 |  | 2812 |  | 2813 |  | 2814 |  | 2815 |  | 2816 |  | 2817 |  | 2818 |  | 2819 |  | 2820 |  | 2821 |  | 2822 |  | 2823 |  | 2824 |  | 2825 |  | 2826 |  | 2827 |  | 2828 |  | 2829 |  | 2830 |  | 2831 |  | 2832 |  | 2833 |  | 2834 |  | 2835 |  | 2836 |  | 2837 |  | 2838 |  | 2839 |  | 2840 |  | 2841 |  | 2842 |  | 2843 |  | 2844 |  | 2845 |  | 2846 |  | 2847 |  | 2848 |  | 2849 |  | 2850 |  | 2851 |  | 2852 |  | 2853 |  | 2854 |  | 2855 |  | 2856 |  | 2857 |  | 2858 |  | 2859 |  | 2860 |  | 2861 |  | 2862 |  | 2863 |  | 2864 |  | 2865 |  | 2866 |  | 2867 |  | 2868 |  | 2869 |  | 2870 |  | 2871 |  | 2872 |  | 2873 |  | 2874 |  | 2875 |  | 2876 |  | 2877 |  | 2878 |  | 2879 |  | 2880 |  | 2881 |  | 2882 |  | 2883 |  | 2884 |  | 2885 |  | 2886 |  | 2887 |  | 2888 |  | 2889 |  | 2890 |  | 2891 |  | 2892 |  | 2893 |  | 2894 |  |
|------------------|--|-----|--|-----|--|------|--|----------|--|----------|--|-----------|--|------------|--|-----------|--|---------------|--|---------------|--|----------------|--|----------------|--|-----------------|--|-----------------------|--|---------------------|--|----------------------|--|-----------------------|--|-----------------------|--|----------------------|--|---------------------------------|--|-----------------------|--|-------------------|--|--------------------------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|-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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

1  
13358  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13365

Reg. Dist. No.

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>                            |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>   |  |
| c. LENGTH OF STAY in 1b<br><b>Hrs.</b>   |  | d. STREET ADDRESS<br><b>927 Spa Road</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>817 Spa Road</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Joseph</b> Middle <b>Kyler</b> Last <b></b>   |  | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>7</b> Year <b>19 60</b>   |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>Colored</b>     | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                   | 8. DATE OF BIRTH<br><b>Oct. 15-1914</b>                                |
| 9. AGE (In years last birthday)<br><b>46</b> yrs.  |  | IF UNDER 1 YEAR<br>Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Gen. Utilities - U.S. Naval Exp. Station</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Annopolis, Maryland</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>U.S.A.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>Thomas Kyler</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Airy Crompton</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO.<br><b>Unknown</b>  |  |
| 17. INFORMANT<br><b>Florence Green- 817 Spa Road-Annapolis, Md.</b>  |  | Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>434.4</b> <b>Cancer</b> DUE TO <b>Sudden</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO (c) <b></b>  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b> 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . |  |  |  |
| ACTUAL SIGNATURE<br><b>E Linhardt</b>  |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |  |
| EXAMINER'S NAME (Type)<br><b>E Linhardt</b>  |  | DATE SIGNED<br><b>12.7-60</b>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 22b. DATE THEREOF<br><b>Dec. 10-60</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Brewer Hill</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Annapolis, Md.</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>C.E. Hicks III</b>  |  | ADDRESS<br><b>Annapolis, Maryland</b>  |  |
| 24a. REC'D BY REGISTRAR<br>DATE <b>DEC 14 '60</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Thomas</b>  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
ISM 9/59

13407

13366

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

|   |                               |  |                                      |  |                             |  |  |
|---|-------------------------------|--|--------------------------------------|--|-----------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ANNE ARUNDEL MARYLAND</b>   |                               |  |                                      | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>3 VOL-4</b> |                             |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MILLERSVILLE About 10 mi</b>  |                               |  |                                      | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 26 -</b>                                     |                             |  |  |
| 3. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Knalwood Nursing Home</b>   |                               |  |                                      | d. STREET ADDRESS <b>1618 CYPRESS ST</b>   |                             |  |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                               |  |                                      |  |                             |  |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><b>STELLA (Estelle) LADNER</b>   |                               |  |                                      | 4. DATE OF DEATH Month Day Year<br><b>DEC. 24 1960</b>   |                             |  |  |
| 5. SEX <b>FEMALE</b>  | 6. COLOR OR RACE <b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>JUNE 10-1886</b> | 9. AGE (In years last birthday) <b>74 yrs.</b>   | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife -</b>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>at home -</b>   |                                      | 11. BIRTHPLACE (State or foreign country) <b>Champaign, Ill.</b>   |                             | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                           |  |
| 13. FATHER'S NAME <b>Samuel Zingling</b>  |                               |  |                                      | 14. MOTHER'S MAIDEN NAME <b>Sadie Reinhardt</b>  |                             |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no -</b>  |                               | 16. SOCIAL SECURITY NO. <b>220-05-4222D</b>  |                                      | 17. INFORMANT Address <b>Robt. L. Ladner (Same)</b>  |                             |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>BRONCHIO PNEUMONIA.</b><br>331X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CEREBRO VASCULAR DISEASE</b> DUE TO<br>(c) <b>4 days.</b><br><b>4 months.</b> |                               |  |                                      | INTERVAL BETWEEN ONSET AND DEATH   |                             |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                               |  |                                      |  |                             |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                               |  |                                      |  |                             |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               |  |                                      | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                             |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m.<br><b>10:20 p. m. 19</b>   |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                      | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                             | 20f. (City or town) (County) (State)                                 |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>12/17</b> 19 <b>60</b> , to <b>12/24</b> 19 <b>60</b> ; that (I) (we) last saw the deceased alive on <b>12/20</b> 19 <b>60</b> ; and that death occurred at <b>10:20 PM</b> , from the causes and on the date stated above.  |                               |  |                                      |  |                             |  |  |
| 22a. SIGNATURE <b>Gerard Church</b>   |                               |  |                                      | 22b. DATE SIGNED <b>12/25/60</b>   |                             |  |  |
| 22c. PHYSICIAN'S NAME (Type) <b>GERARD CHURCH</b>   |                               |  |                                      | 22d. ADDRESS <b>121 CATHEDRAL ST BALTIMORE</b>   |                             |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>   |                               | 23b. DATE THEREOF <b>Dec. 28-1960</b>  |                                      | 23c. NAME OF CEMETERY OR CREMATORY <b>Green Haven Cem.</b>   |                             | 23d. LOCATION (City, town, or county) (State) <b>Green Belts Md.</b> |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>ANGUARD EVANSON</b>   |                               |  |                                      | 25a. REC'D BY REGISTRAR ADDRESS <b>4005 CHARLES ST BALTO 30 MD</b>   |                             | 25b. REGISTRAR'S SIGNATURE   |  |
|   |                               |  |                                      | DATE <b>DEC 28 '60</b>   |                             |  |  |

John J. Anna

15508

CERTIFICATE OF DEATH

13401



*[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Some words like "Name", "Age", "Sex", "Race", "Date of Birth", "Date of Death", "Cause of Death", "Place of Death", "Signature", and "Witness" are faintly visible.]*

①

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 13359 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13367

Reg. Dist. No.

|   |  |  |                                 |  |  |   |   |   |  |
|---|--|--|---------------------------------|--|--|---|---|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <b>Anne Arundel</b> MARYLAND  |  |  |                                 | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>                     |  |   |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>  |  |  | c. LENGTH OF STAY IN 1b<br><br> |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>10 Annapolis</b> |   |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>DOA Anne Arundel General Hospital</b>  |  |  |                                 | d. STREET ADDRESS<br><b>1 53 1/2 West Street</b>   |  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| <b>3. NAME OF DECEASED</b> (Type or print)<br>First Middle Last<br><b>DORMAN H LEWIS</b>  |  |  |                                 | <b>4. DATE OF DEATH</b><br>Month Day Year<br><b>DECEMBER 3, 1960</b>   |  |   |   |   |  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>White</b>                                   |                                 | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                |  | 8. DATE OF BIRTH<br><b>Sept 15, 1935</b>  |   | 9. AGE (In years last birthday)<br><b>25 yrs.</b>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Equipment Operator</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Road Const.</b>            |                                 | 11. BIRTHPLACE (State or foreign country)<br><b>N.C.</b>   |  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |  |
| 13. FATHER'S NAME<br><b>Robert Hayes Lewis</b>  |  |  |                                 | 14. MOTHER'S MAIDEN NAME<br><b>Maudy Walston</b>   |  |   |   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>   |  | 16. SOCIAL SECURITY NO.<br><b>212 50 3576</b>                      |                                 | 17. INFORMANT Address<br><b>Mrs Laverne Cox Lewis- Wife- Same as # 2</b>   |  |   |   |   |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Fracture Skull</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)<br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)      |  |  |                                 |  |  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 day</b>  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>   |  |  |                                 |  |  |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Auto accident Rt. 750</b>  |  |  |                                 | 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>12-3 1960</b>  |  |   |   |   |  |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>   |  |  |                                 | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Highway</b>   |  | 20f. (City or town) (County) (State)<br><b>Adas MS</b>  |   |   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |  |  |                                 |  |  |   |   |   |  |
| ACTUAL SIGNATURE<br><b>Elmer G. Linhardt</b>  |  |  |                                 | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |  |   |   | DATE SIGNED<br><b>12/3/60</b>   |  |
| EXAMINER'S NAME (Type)<br><b>Elmer G. Linhardt</b>  |  | 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal-Burial</b> |                                 |  |  |   |   |   |  |
| 22b. DATE THEREOF<br><b>Dec. 5, 1960</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Southport Cemetery</b>    |                                 |  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Southport, N.C.</b>                                 |   |   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>HOPPING FUNERAL HOME</b>   |  |  |                                 | ADDRESS<br><b>Annapolis, Maryland</b>  |  |   |   | 24a. REC'D BY REGISTRAR<br><b>DEC 7 '60</b>   |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>Charles S. Priddy</b>  |  |  |                                 | DATE   |  |   |   |   |  |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|                       |  |                      |  |                        |  |                      |  |
|-----------------------|--|----------------------|--|------------------------|--|----------------------|--|
| Name of Deceased      |  | Sex                  |  | Age                    |  | Date of Death        |  |
| [Blank]               |  | [Blank]              |  | [Blank]                |  | [Blank]              |  |
| Place of Birth        |  | Usual Residence      |  | Cause of Death         |  | Manner of Death      |  |
| [Blank]               |  | [Blank]              |  | [Blank]                |  | [Blank]              |  |
| Occupation            |  | Education            |  | Previous Illnesses     |  | Injury or Poison     |  |
| [Blank]               |  | [Blank]              |  | [Blank]                |  | [Blank]              |  |
| Social History        |  | Family History       |  | Autopsy                |  | Remarks              |  |
| [Blank]               |  | [Blank]              |  | [Blank]                |  | [Blank]              |  |
| Signature of Examiner |  | Signature of Coroner |  | Signature of Physician |  | Signature of Witness |  |
| [Blank]               |  | [Blank]              |  | [Blank]                |  | [Blank]              |  |
| Date of Signature     |  | Time of Signature    |  | Place of Signature     |  | Initials of Deceased |  |
| [Blank]               |  | [Blank]              |  | [Blank]                |  | [Blank]              |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13379

## CERTIFICATE OF DEATH

13368

Reg. Dist. No.

|  |  |  |  |  |  |  |   |
|--|--|--|--|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>          |  |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RIVIERA BEACH</u>  |  |  |  | c. LENGTH OF STAY IN 1b <u>30 YEARS</u>  |  |  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8442 GARDEN ROAD</u>   |  |  |  | e. STREET ADDRESS <u>18442 GARDEN ROAD</u>   |  |  |   |
| 3. NAME OF DECEASED (Type or print) First <u>CATHERINE</u> Middle <u>ANN</u> Last <u>MARTIN</u>  |  |  |  | 4. DATE OF DEATH Month <u>DEC.</u> Day <u>29</u> Year <u>1960</u>  |  |  |   |
| 5. SEX <u>FEMALE</u>   |  | 6. COLOR OR RACE <u>WHITE</u>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>AUG. 3, 1918</u>                                 |   |
| 9. AGE (In years last birthday) <u>42</u> yrs.   |  | IF UNDER 1 YEAR Months Days Hours Min.   |  | IF UNDER 24 HRS. Months Days Hours Min.  |  |  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>  |  | 11. BIRTHPLACE (State or foreign country) <u>BALTO., MD.</u>         |   |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |  |  |  |  |  |   |
| 13. FATHER'S NAME <u>MILLARD F. DOWNEY</u>   |  |  |  | 14. MOTHER'S MAIDEN NAME <u>MARY A. GARDINER</u>   |  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)  |  |  |  | 16. SOCIAL SECURITY NO. <u>219-16-4803</u>   |  | 17. INFORMANT Address <u>Mrs. JUDY HENINGSEN SAME</u>                |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARCINOMA BREAST WITH METASTASES</u><br><u>170X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____<br>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>11 months</u> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. _____ p. m. _____ 19 _____  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) _____ (County) _____ (State) _____               |   |
| 21. I certify that I attended the deceased from <u>FEB.</u> 19 <u>40</u> , to <u>DEC. 29, 1960</u> , that I last saw the deceased alive on <u>DEC. 28, 1960</u> , and that death occurred at <u>9:05A</u> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <u>8442 FT. SMALLWOOD ROAD PASADENA, MARYLAND</u> DATE SIGNED <u>12/29/60</u>  |  |  |  |  |  |  |   |
| ACTUAL SIGNATURE <u>J. Brady Smith</u> M.D.  |  |  |  | PHYSICIAN'S NAME (Type) <u>J. BRADY SMITH</u>  |  |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  | 22b. DATE THEREOF <u>Jan. 3, 1961</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>   |  | 22d. LOCATION (City, town, or county) (State) <u>A H County, Md.</u> |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Fred A. Cole</u> ADDRESS <u>1913 W. Balto. St.</u>   |  |  |  | 24a. REC'D BY REGISTRAR DATE <u>JAN 3 '61</u>  |  | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>                   |   |







# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 13408

## CERTIFICATE OF DEATH

## 13369

Reg. Dist. No.

|   |   |   |   |
|---|---|---|---|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Anne Arundle</u> <u>MARYLAND</u>   |   | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundl</u>           |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Harmons (Glen Burnie)</u>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Glen Burnie</u>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Box #440 Hanover Md.</u>   |   | d. STREET ADDRESS<br><u>Box #440 Harmons Md.</u>  |   |
| <b>3. NAME OF DECEASED</b><br>(Type or print) First <u>Theodore</u> Middle <u>Matthews</u> Last <u></u>   |   | <b>4. DATE OF DEATH</b> Month <u>Dec.</u> Day <u>22</u> Year <u>1960</u>  |   |
| <b>5. SEX</b><br><u>Male</u>  | <b>6. COLOR OR RACE</b><br><u>Colored</u>   | <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | <b>8. DATE OF BIRTH</b><br><u>July 15, 1907</u>                                 |
| <b>9. AGE</b> (In years last birthday) yrs. <u>53</u>   |   | <b>10. IF UNDER 1 YEAR</b> Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>   |   |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>Contractor</u>   |   | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><u>Building</u>   |   |
| <b>11. BIRTHPLACE</b> (State or foreign country)<br><u>Harmons Md.</u>  |   | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>U.S.A.</u>  |   |
| <b>13. FATHER'S NAME</b><br><u>Nicholas Matthews</u>  |   | <b>14. MOTHER'S MAIDEN NAME</b><br><u>Rossie Oliver</u>   |   |
| <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service)  |   | <b>16. SOCIAL SECURITY NO.</b><br><u>717-07-6750</u>  |   |
| <b>17. INFORMANT</b> Address<br><u>Helen L. Matthews Box #440 Harmons Md.</u>   |   |   |   |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Abdominal Carcinomatosis</u><br><u>151X</u> DUE TO <u>Carcinoma of Stomach</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u><br>DUE TO <u></u> |   | <b>INTERVAL BETWEEN ONSET AND DEATH</b><br><u>2 mo.</u><br><u>5 mo.</u>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>   |   |   |   |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)   |   |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a. m. <u>19</u> p. m. <u></u>   |   | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |   |
| <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)   |   | <b>20f. (City or town)</b> (County) (State)   |   |
| <b>21. I certify that I attended the deceased from</b> <u>Sept. 30</u> , 19 <u>60</u> , to <u>December 22</u> , 19 <u>60</u> , that last saw the deceased alive on <u>Dec. 22</u> , 19 <u>60</u> , and that death occurred at <u>6 P.</u> M, from the causes and on the date stated above.  |   |   |   |
| <b>ACTUAL SIGNATURE</b> <u>Frank E. Shipley</u> M.D.  |   | <b>ADDRESS</b> (Street, city or town, state) <u>Savage. Md. 12/24/60</u>  |   |
| <b>NAME (Type)</b> <u>Frank E. Shipley, M.D.</u>  |   | <b>DATE SIGNED</b>  |   |
| <b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br><u>Burial</u>   | <b>22b. DATE THEREOF</b><br><u>12/26/60</u> | <b>22c. NAME OF CEMETERY OR CREMATORY</b><br><u>Sts Rest Cemetery</u>   | <b>22d. LOCATION</b> (City, town, or county) (State)<br><u>Harmons Maryland</u> |
| <b>23. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>Herbert E. Nutter-3035 W. North Ave.</u>  |   | <b>24a. REC'D BY REGISTRAR</b><br><b>DATE</b> <u>DEC 27 1960</u>  | <b>24b. REGISTRAR'S SIGNATURE</b><br><u>Arthur E. King</u>                      |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6032

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13409

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13370

|   |                              |   |                                      |  |   |   |  |
|---|------------------------------|---|--------------------------------------|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>A. A. CO</u> MARYLAND   |                              |   |                                      | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u> |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Crownsville.</u>   |                              | c. LENGTH OF STAY IN 1b<br><u>9 days.</u>   |                                      | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Baltimore - MD</u> <u>3V01-9</u>                |   |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Crownsville - State Hosp.</u>  |                              |   |                                      | d. STREET ADDRESS<br><u>Baker - St</u>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Robert (Rothert)</u> Middle <u>McCracken</u> Last <u>McCracken</u>  |                              |   |                                      | 4. DATE OF DEATH<br>Month <u>12</u> Day <u>25</u> Year <u>1960</u>   |   |   |  |
| 5. SEX<br><u>M</u>  | 6. COLOR OR RACE<br><u>C</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>7-15-1900</u> |  | 9. AGE (In years last birthday)<br><u>60 yrs.</u> | 10. IF UNDER 1 YEAR<br>Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>                 |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Painter</u>   |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>unknown</u>   |                                      | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U. S. A</u>  |  |
| 13. FATHER'S NAME<br><u>Louis Mc Cracken</u>  |                              |   |                                      | 14. MOTHER'S MAIDEN NAME<br><u>Mary ?</u>  |   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>No</u>   |                              | 16. SOCIAL SECURITY NO.<br><u>215-10-0640</u>   |                                      | 17. INFORMANT<br><u>Hospital Records</u>   |   | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Subdural-Hemorrhage</u><br>936.9 DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <u>Fracture - Skull</u><br>(a), stating the underlying cause last. DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome associated w. Chronic alcoholism</u> |                              |   |                                      |  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>?</u> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>  |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                      |  |   |   |  |
| 20c. TIME OF INJURY<br>Hour <u>before</u> a. m. <u>12/16/</u> 1960  |                              | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                      | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>unknown</u>   |   | 20f. (City or town) <u>Baltimore</u> (County) <u>MD</u> (State)                                   |  |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input checked="" type="checkbox"/> .   |                              |   |                                      |  |   |   |  |
| ACTUAL SIGNATURE <u>E. L. Linhardt</u>  |                              |   |                                      | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   |   |  |
| EXAMINER'S NAME (Type) <u>E. L. Linhardt</u>  |                              |   |                                      | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |   |   |  |
|   |                              |   |                                      | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |   |   |  |
| 22a. BURIAL, CREMATION, or REMOVAL (Specify)<br><u>12/28/60</u>   |                              | 22b. DATE THEREOF   |                                      | 22c. NAME OF CEMETERY OR CREMATORY<br><u>St. Calvary</u>   |   | 22d. LOCATION (City, town, or county) <u>Baltimore</u> (State) <u>MD</u>                          |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>H. Halstead</u>  |                              |   |                                      | ADDRESS<br><u>7</u>  |   | 24a. REC'D BY REGISTRAR<br>DATE <u>JAN 3 '61</u>  |  |
|   |                              |   |                                      | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Hanes</u>   |   |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

13360

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13371

|  |                                  |   |                                       |
|--|----------------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>             |                                       |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>10 Annapolis</b>   |                                       |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Anne Arundel General Hospital</b>   |                                  | d. STREET ADDRESS<br><b>1214 Sumner Road</b>  |                                       |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |   |                                       |
| 3. NAME OF DECEASED (Type or print)<br>First <b>William</b> Middle <b>B.</b> Last <b>McInnis</b>   |                                  | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>19</b> Year <b>1960</b>  |                                       |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>10-23-1880</b> |
| 9. AGE (In years last birthday)<br><b>80</b> yrs.  |                                  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   | 11. IF UNDER 24 HRS.<br>Hours Min.    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>RET. SHOE SALESMAN</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>SHOE STORE</b>  |                                       |
| 11. BIRTHPLACE (State or foreign country)<br><b>CANADA</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |                                       |
| 13. FATHER'S NAME<br><b>SAMUEL McINNIS</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>ANN MAC DONALD</b>   |                                       |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>—</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>—</b>   |                                       |
| 17. INFORMANT<br><b>EMMA H. McINNIS</b>  |                                  | Address<br><b>#2</b>  |                                       |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b><br><b>332X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis</b> DUE TO<br>(c) <b>—</b> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 wks</b>  |                                       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                       |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                       |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>   |                                       |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |                                       |
| 21. I certify that (I) (this hospital) attended the deceased from <b>11-15-60</b> to <b>12-19-60</b> , that (I) (we) last saw the deceased alive on <b>12-19-60</b> , and that death occurred at <b>9:50</b> from the causes and on the date stated above.   |                                  |   |                                       |
| 22a. SIGNATURE<br><b>Frank M. Shipley</b>  |                                  | 22b. DATE SIGNED<br><b>12-18-60</b>   |                                       |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Dr. Frank Shipley</b>   |                                  | 22d. ADDRESS<br><b>Cathedral St., Annapolis, Md.</b>  |                                       |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                                  | 23b. DATE THEREOF<br><b>12-20-60</b>  |                                       |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>BLOSSOM HILL</b>  |                                  | 23d. LOCATION (City, town, or county) (State)<br><b>CONCORD N.H.</b>  |                                       |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>John M. G. &amp; Sons</b>   |                                  | 25a. REC'D BY REGISTRAR<br>DATE <b>DEC 23 '60</b>   |                                       |
| 25b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kram</b>  |                                  |   |                                       |

18371

CERTIFICATE OF DEATH

18371

Anna Arundel

Maryland

Anna Arundel

Annapolis

Annapolis

311 Summer Road

Anna Arundel General Hospital

Melinda

William

December

19

00

White

Male

Dr. Frank Shipley  
Cathedral St., Annapolis, Md.



CERTIFICATE OF DEATH

Reg. Dist. No.

|   |   |   |  |
|---|---|---|--|
| 1. PLACE OF DEATH<br>o. COUNTY <b>AA</b> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>AA</b>                       |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Brooklyn</b>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>50 Brooklyn</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>8 W. 3rd Ave.</b>  |   | d. STREET ADDRESS<br><b>1 8 W. 3rd Ave.</b>   |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Lilly</b> Middle <b>M.</b> Last <b>Meseke</b>   |   | 4. DATE OF DEATH<br>Month <b>12</b> Day <b>1</b> Year <b>19 60</b>  |  |
| 5. SEX<br><b>F</b>  | 6. COLOR OR RACE<br><b>W</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>11/3/77</b>                                     |
| 9. AGE (In years last birthday)<br><b>83</b> yrs.   |   | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Md.</b>  |   | 12. CITIZEN OF WHAT COUNTRY?  |  |
| 13. FATHER'S NAME<br><b>James Hutton</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>James Mary Reinecker</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>  |   | 16. SOCIAL SECURITY NO.<br><b>INFORMANT</b> Address <b>Family Same</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br><b>422.1</b> IMMEDIATE CAUSE (a) <b>Myocardial Insufficiency</b><br>DUE TO (b) <b>Arterio sclerosis +</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Myocarditis</b> |   | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                   |
| 21. I certify that I attended the deceased from <b>Nov 23 1960</b> to <b>Dec 1 1960</b> , that I last saw the deceased alive on <b>November 30, 1960</b> , and that death occurred at <b>1158</b> M, from the causes and on the date stated above.  |   |   |  |
| ACTUAL SIGNATURE<br><b>John A. Scheurich M.D.</b>   |   | DATE SIGNED<br><b>1237 S. Charles St Baltimore 30th 7/60</b>  |  |
| PHYSICIAN'S NAME (Type)<br><b>John A. Scheurich M.D.</b>  |   |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>B</b>   | 22b. DATE THEREOF<br><b>12/5/60</b>   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Pk. Cem.</b>  | 22d. LOCATION (City, town, or county) (State)<br><b>Baltimore, Md.</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>McCully Funeral Homes 130 E. Fort Ave.</b>   |   | 24a. REC'D BY REGISTRAR<br>DATE <b>DEC 5 '60</b>  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kusan.</b>                  |

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)  
ISM 9/58

1933



CERTIFICATE OF DEATH

1910

1. Name of deceased  
2. Sex  
3. Age  
4. Date of birth  
5. Place of birth  
6. Date of death  
7. Place of death  
8. Cause of death  
9. Signature of physician  
10. Signature of registrar

11. Name of informant  
12. Address of informant  
13. Date of completion  
14. Signature of informant  
15. Signature of registrar  
16. Signature of physician  
17. Signature of health officer  
18. Signature of coroner  
19. Signature of jury  
20. Signature of witnesses

Recorded and indexed by the Registrar General

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

VS. A15ME  
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
13411 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13373

|  |                              |   |                                    |   |   |   |  |
|--|------------------------------|---|------------------------------------|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>MARYLAND</u>   |                              |   |                                    | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Same</u> b. COUNTY <u>Same</u> |   |   |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Severn</u>  |                              | c. LENGTH OF STAY IN lb<br><u>4 years</u>   |                                    | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Same</u>                                     |   |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>Box 233B Queenstown Rd.</u>   |                              |   |                                    | d. STREET ADDRESS<br><u>Same</u>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>Lucille Mills</u>  |                              |   |                                    | 4. DATE OF DEATH<br>Month <u>December</u> Day <u>18th.</u> Year <u>19 60</u>  |   |   |  |
| 5. SEX<br><u>F</u>   | 6. COLOR OR RACE<br><u>C</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>9/21/15</u> |   | 9. AGE (In years last birthday)<br><u>45</u> yrs. | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u>  | IF UNDER 24 HRS.<br>Hours <u>  </u> Min. <u>  </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housework</u>  |                              | 10b. KIND OF BUSINESS OR INDUSTRY   |                                    | 11. BIRTHPLACE (State or foreign country)<br><u>Jacksonville, Fla.</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  |
| 13. FATHER'S NAME<br><u>William Singletary</u>   |                              |   |                                    | 14. MOTHER'S MAIDEN NAME<br><u>Sally Brown</u>  |   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><u>No</u>   |                              | 16. SOCIAL SECURITY NO.   |                                    | 17. INFORMANT<br><u>Mrs. Emma Moses (sister).</u>   |   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u><br><u>420.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)     |                              |   |                                    |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>Sudden</u>   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                              | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)   |                                    |   |   |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour <u>  </u> a.m. <u>  </u> p.m. <u>19</u>  |                              | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |                                    | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> end in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                              |   |                                    |   |   |   |  |
| ACTUAL SIGNATURE <u>Custave H. Faubert, M.D.</u>   |                              |   |                                    | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   |   |  |
| EXAMINER'S NAME (Type) <u>Custave H. Faubert, M.D.</u>   |                              |   |                                    | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |   |   |  |
|  |                              |   |                                    | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |   |   |  |
|  |                              |   |                                    | DATE SIGNED <u>12/18/60</u>   |   |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                              | 22b. DATE THEREOF<br><u>12/23/60</u>  |                                    | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Arbutus Mem. Pk.</u>   |   | 22d. LOCATION (City, town, or country) (State)<br><u>Arbutus, Md</u>                              |  |
| 23. FUNERAL DIRECTOR<br><u>Joseph B. Rocks, Jr</u>   |                              |   |                                    | ADDRESS<br><u>1304 N. Central St</u>  |   | 24a. REC'D BY REGISTRAR<br>DATE <u>DEC 21 '60</u>   |  |
|  |                              |   |                                    | 24b. REGISTRAR'S SIGNATURE<br><u>Curtis L. Hines</u>  |   |   |  |

MEDICAL CERTIFICATION

THE STATE  
OF NEW YORK

1941

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1941

DEC 1 1941

1  
 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

13374

13412

|   |                                   |   |  |
|---|-----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b><br>c. LENGTH OF STAY IN 1b <b>3 mos. 8 days</b>   |                                   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Baltimore City</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>  |                                   | d. STREET ADDRESS <b>2216 Ruskin Avenue</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Harry</b> Middle <b>Nelson</b> Last <b>Nelson</b>   |                                   | 4. DATE OF DEATH<br>Month <b>12</b> Day <b>28</b> Year <b>19 60</b>   |  |
| 5. SEX <b>Male</b>  | 6. COLOR OR RACE <b>Negro</b>     | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH <b>5/21/85</b>                                      |
| 9. AGE (In years last birthday) <b>75</b> yrs.  |                                   | IF UNDER 1 YEAR: Months <b>7</b> Days <b>15</b> Hours <b>0</b> Min. <b>0</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unempl. Pension</b>  |                                   | 10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>  | 11. BIRTHPLACE (State or foreign country) <b>Maryland</b>            |
| 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |                                   | 13. FATHER'S NAME <b>Henry Nelson</b>   |  |
| 14. MOTHER'S MAIDEN NAME <b>Eliza Gaither</b>   |                                   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>   |  |
| 16. SOCIAL SECURITY NO. <b>212-32-1763</b>  |                                   | 17. INFORMANT <b>Hospital Records</b> Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary Embolism</b><br>DUE TO <b>Heart Infarction</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Coronary Thrombosis</b><br>(b) <b>Coronary Thrombosis</b><br>(c) <b>Coronary Thrombosis</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Brain Syndrome associated with Arteriosclerosis</b> |                                   |   |  |
| INTERVAL BETWEEN ONSET AND DEATH  |                                   |   |  |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <b>10</b> p. m. <b>19</b>  |                                   | 20d. INJURY OCCURRED While <input type="checkbox"/> at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <b>factory street office bldg.</b>  |                                   | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>9/20</b> <b>1960</b> to <b>12/28</b> <b>1960</b> , that (I) (we) last saw the deceased alive on <b>12/28</b> <b>1960</b> , and that death occurred at <b>4:45</b> <b>PM</b> , from the causes and on the date stated above.  |                                   |   |  |
| 22a. SIGNATURE <b>L. Benedict, M.D.</b>   |                                   | 22b. DATE SIGNED <b>Dec 28, 1960</b>  |  |
| 22c. PHYSICIAN'S NAME (Type) <b>L. Benedict, M.D.</b>   |                                   | 22d. ADDRESS <b>Crownsville State Hospital, Maryland</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>   | 23b. DATE THEREOF <b>12/31/60</b> | 23c. NAME OF CEMETERY OR CREMATORY <b>ST. MATTHEWS</b>  | 23d. LOCATION (City, town, or county) (State) <b>JOHNSVILLE, Md.</b> |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>Charles R. Law</b>  |                                   | 25a. REC'D BY REGISTRAR <b>JAN 3 '61</b>  |  |
| ADDRESS <b>802-Madison AVE.</b>   |                                   | 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>   |  |

18374

CERTIFICATE OF DEATH

18412

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1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
13413 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13375

|  |  |                              |  |   |  |  |  |   |  |  |  |
|--|--|------------------------------|--|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><u>Anne Arundel</u>  |  |                              |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><u>Maryland</u>  |  |  |  | b. COUNTY<br><u>A.A.</u>  |  |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Pasadena</u>  |  |                              |  | c. LENGTH OF STAY IN 1b<br><u>Few seconds</u>   |  |  |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Pasadena</u> |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>Bahama Beach</u>  |  |                              |  |   |  |  |  | d. STREET ADDRESS<br><u>1 Colonial Beach Drive</u>  |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><u>Joseph Lee Patterson</u>  |  |                              |  | 4. DATE OF DEATH<br><u>December 14th</u>  |  |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 5. SEX<br><u>M</u>   |  | 6. COLOR OR RACE<br><u>W</u> |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>July 8, 1902</u>                                |  | 9. AGE (In years last birthday)<br><u>58</u> yrs.   |  | IF UNDER 1 YEAR<br>Months Days                       |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Taxi driver</u>  |  |                              |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Taxi cab</u>  |  |  |  | 11. BIRTHPLACE (State or foreign country)<br><u>Pennsylvania</u>                                    |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>           |  |
| 13. FATHER'S NAME<br><u>Unknown</u>  |  |                              |  | 14. MOTHER'S MAIDEN NAME<br><u>Unknown</u>  |  |  |  |   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)<br><u>No</u>  |  |                              |  | 16. SOCIAL SECURITY NO.<br><u></u>  |  |  |  | 17. INFORMANT<br><u>Alice I. Patterson</u> Address<br><u>1 Colonial Beach Drive</u>                 |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u><br><u>420.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                              |  |   |  |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>Sudden</u>    |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  |                              |  | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |   |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m.<br>p.m.<br><u>19</u>  |  |                              |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  | 20f. (City or town)<br>(County)<br>(State)  |  |  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>   |  |                              |  |   |  |  |  |   |  |  |  |
| ACTUAL SIGNATURE<br><u>Gustave H. Faubert</u>  |  |                              |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |  |  | DATE SIGNED<br><u>12/15/60</u>  |  |  |  |
| EXAMINER'S NAME (Type)<br><u>Gustave H. Faubert, M.D.</u>  |  |                              |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |  |  |   |  |  |  |
|  |  |                              |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |  |  |   |  |  |  |
|  |  |                              |  | Address (Street, city, town, or county)<br><u></u>  |  |  |  |   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  |                              |  | 22b. DATE THEREOF<br><u>12/19/60</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Glen Haven Cemetery</u>       |  | 22d. LOCATION (City, town, or country) (State)<br><u>Glen Burnie Anne Arundel, Md.</u>              |  |  |  |
| 23. FUNERAL DIRECTOR<br><u>Umbrage, Inc. 1528 Sulphur Spring Rd.</u>   |  |                              |  | ADDRESS<br><u></u>  |  |  |  | 24a. REC'D BY REGISTRAR<br><u>DEC 20 '60</u>  |  | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Kline</u> |  |

BP

1935

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1935

FOR THE

STATE OF

NEW YORK

County of

City of

State of

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## CERTIFICATE OF DEATH

13376

Reg. Dist. No.

13414

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|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>   |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PIKE GROVE VILLAGE</u>  |  |   |  | c. LENGTH OF STAY IN 1b <u>9/1005</u>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PRISADENA 108 SANDY BEACH DR.</u>   |  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |
| 3. NAME OF DECEASED (Type or print) <u>ANDREW E. PETERSON</u>   |  |   |  | 4. DATE OF DEATH <u>Dec. 25 1960</u>  |  |  |  |
| 5. SEX <u>MALE</u>  |  | 6. COLOR OR RACE <u>WHITE</u>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH <u>Sept. 4 - 1879</u>   |  |
| 9. AGE (In years last birthday) <u>81</u> yrs.  |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rigger</u> |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Bethlehem SHIPYARD -</u>   |  | 11. BIRTHPLACE (State or foreign country) <u>DENMARK</u>                                       |  |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |  |   |  | 13. FATHER'S NAME <u>PETERSON</u>   |  |  |  |
| 14. MOTHER'S MAIDEN NAME <u>P</u>   |  |   |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>  |  |  |  |
| 16. SOCIAL SECURITY NO. <u>213-03-844</u>   |  |   |  | 17. INFORMANT <u>CHARLES C. ALBAUGH</u> Address <u>SAME</u>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Congestive heart failure</u><br>420.9 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary heart disease</u><br>DUE TO<br>(c) _____ |  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>3 yrs.</u><br><u>10 yrs.</u>                            |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senile Dementia</u>  |  |   |  |   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. _____ p. m. _____ 19 _____   |  |   |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                         |  |
| 20f. (City or town) _____ (County) _____ (State) _____  |  |   |  | 21. I certify that I attended the deceased from <u>25 Dec., 1960</u> , to <u>25 Dec., 1960</u> , that I last saw the deceased alive on <u>25 Dec., 1960</u> , and that death occurred at <u>7:20 PM</u> , from the causes and on the date stated above. |  |  |  |
| ACTUAL SIGNATURE <u>John Kehoe</u> M.D. <u>2004 RITCHIE HIGHWAY</u>   |  |   |  | DATE SIGNED _____   |  |  |  |
| PHYSICIAN'S NAME (Type) <u>John Kehoe</u>   |  |   |  | ADDRESS (Street, city or town, state) <u>GLEN BURNIE, MD.</u>   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>   |  | 22b. DATE THEREOF <u>Dec. 29, 1960</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY <u>MEADOW RIDGE - cem, POREY, MD.</u>  |  | 22d. LOCATION (City, town, or county) (State) _____  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John Kehoe</u> ADDRESS <u>14005 CHAPMAN ST, POREY, MD.</u>  |  |   |  | 24a. REC'D BY REGISTRAR <u>28 '60</u>   |  | 24b. REGISTRAR'S SIGNATURE <u>Anthony S. K...</u>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10398

CERTIFICATE OF DEATH

13414

|   |  |  |  |
|---|--|--|--|
| <p>1. Name of deceased: <i>John W. Smith</i></p>      |  | <p>2. Date of death: <i>Dec 15, 1900</i></p>             |  |
| <p>3. Place of death: <i>Home</i></p>                 |  | <p>4. Cause of death: <i>Heart failure</i></p>           |  |
| <p>5. Age: <i>65</i></p>                              |  | <p>6. Sex: <i>Male</i></p>                               |  |
| <p>7. Occupation: <i>Teacher</i></p>                  |  | <p>8. Marital status: <i>Married</i></p>                 |  |
| <p>9. Name of informant: <i>John W. Smith</i></p>     |  | <p>10. Signature of informant: <i>[Signature]</i></p>    |  |
| <p>11. Name of physician: <i>Dr. J. H. Jones</i></p>  |  | <p>12. Signature of physician: <i>[Signature]</i></p>    |  |
| <p>13. Name of registrar: <i>John W. Smith</i></p>    |  | <p>14. Signature of registrar: <i>[Signature]</i></p>    |  |
| <p>15. Name of funeral home: <i>John W. Smith</i></p> |  | <p>16. Signature of funeral home: <i>[Signature]</i></p> |  |
| <p>17. Name of cemetery: <i>John W. Smith</i></p>     |  | <p>18. Signature of cemetery: <i>[Signature]</i></p>     |  |
| <p>19. Name of undertaker: <i>John W. Smith</i></p>   |  | <p>20. Signature of undertaker: <i>[Signature]</i></p>   |  |
| <p>21. Name of coroner: <i>John W. Smith</i></p>      |  | <p>22. Signature of coroner: <i>[Signature]</i></p>      |  |
| <p>23. Name of jury: <i>John W. Smith</i></p>         |  | <p>24. Signature of jury: <i>[Signature]</i></p>         |  |
| <p>25. Name of jury: <i>John W. Smith</i></p>         |  | <p>26. Signature of jury: <i>[Signature]</i></p>         |  |
| <p>27. Name of jury: <i>John W. Smith</i></p>         |  | <p>28. Signature of jury: <i>[Signature]</i></p>         |  |
| <p>29. Name of jury: <i>John W. Smith</i></p>         |  | <p>30. Signature of jury: <i>[Signature]</i></p>         |  |
| <p>31. Name of jury: <i>John W. Smith</i></p>         |  | <p>32. Signature of jury: <i>[Signature]</i></p>         |  |
| <p>33. Name of jury: <i>John W. Smith</i></p>         |  | <p>34. Signature of jury: <i>[Signature]</i></p>         |  |
| <p>35. Name of jury: <i>John W. Smith</i></p>         |  | <p>36. Signature of jury: <i>[Signature]</i></p>         |  |
| <p>37. Name of jury: <i>John W. Smith</i></p>         |  | <p>38. Signature of jury: <i>[Signature]</i></p>         |  |
| <p>39. Name of jury: <i>John W. Smith</i></p>         |  | <p>40. Signature of jury: <i>[Signature]</i></p>         |  |
| <p>41. Name of jury: <i>John W. Smith</i></p>         |  | <p>42. Signature of jury: <i>[Signature]</i></p>         |  |
| <p>43. Name of jury: <i>John W. Smith</i></p>         |  | <p>44. Signature of jury: <i>[Signature]</i></p>         |  |
| <p>45. Name of jury: <i>John W. Smith</i></p>         |  | <p>46. Signature of jury: <i>[Signature]</i></p>         |  |
| <p>47. Name of jury: <i>John W. Smith</i></p>         |  | <p>48. Signature of jury: <i>[Signature]</i></p>         |  |
| <p>49. Name of jury: <i>John W. Smith</i></p>         |  | <p>50. Signature of jury: <i>[Signature]</i></p>         |  |
| <p>51. Name of jury: <i>John W. Smith</i></p>         |  | <p>52. Signature of jury: <i>[Signature]</i></p>         |  |
| <p>53. Name of jury: <i>John W. Smith</i></p>         |  | <p>54. Signature of jury: <i>[Signature]</i></p>         |  |
| <p>55. Name of jury: <i>John W. Smith</i></p>         |  | <p>56. Signature of jury: <i>[Signature]</i></p>         |  |
| <p>57. Name of jury: <i>John W. Smith</i></p>         |  | <p>58. Signature of jury: <i>[Signature]</i></p>         |  |
| <p>59. Name of jury: <i>John W. Smith</i></p>         |  | <p>60. Signature of jury: <i>[Signature]</i></p>         |  |
| <p>61. Name of jury: <i>John W. Smith</i></p>         |  | <p>62. Signature of jury: <i>[Signature]</i></p>         |  |
| <p>63. Name of jury: <i>John W. Smith</i></p>         |  | <p>64. Signature of jury: <i>[Signature]</i></p>         |  |
| <p>65. Name of jury: <i>John W. Smith</i></p>         |  | <p>66. Signature of jury: <i>[Signature]</i></p>         |  |
| <p>67. Name of jury: <i>John W. Smith</i></p>         |  | <p>68. Signature of jury: <i>[Signature]</i></p>         |  |
| <p>69. Name of jury: <i>John W. Smith</i></p>         |  | <p>70. Signature of jury: <i>[Signature]</i></p>         |  |
| <p>71. Name of jury: <i>John W. Smith</i></p>         |  | <p>72. Signature of jury: <i>[Signature]</i></p>         |  |
| <p>73. Name of jury: <i>John W. Smith</i></p>         |  | <p>74. Signature of jury: <i>[Signature]</i></p>         |  |
| <p>75. Name of jury: <i>John W. Smith</i></p>         |  | <p>76. Signature of jury: <i>[Signature]</i></p>         |  |
| <p>77. Name of jury: <i>John W. Smith</i></p>         |  | <p>78. Signature of jury: <i>[Signature]</i></p>         |  |
| <p>79. Name of jury: <i>John W. Smith</i></p>         |  | <p>80. Signature of jury: <i>[Signature]</i></p>         |  |
| <p>81. Name of jury: <i>John W. Smith</i></p>         |  | <p>82. Signature of jury: <i>[Signature]</i></p>         |  |
| <p>83. Name of jury: <i>John W. Smith</i></p>         |  | <p>84. Signature of jury: <i>[Signature]</i></p>         |  |
| <p>85. Name of jury: <i>John W. Smith</i></p>         |  | <p>86. Signature of jury: <i>[Signature]</i></p>         |  |
| <p>87. Name of jury: <i>John W. Smith</i></p>         |  | <p>88. Signature of jury: <i>[Signature]</i></p>         |  |
| <p>89. Name of jury: <i>John W. Smith</i></p>         |  | <p>90. Signature of jury: <i>[Signature]</i></p>         |  |
| <p>91. Name of jury: <i>John W. Smith</i></p>         |  | <p>92. Signature of jury: <i>[Signature]</i></p>         |  |
| <p>93. Name of jury: <i>John W. Smith</i></p>         |  | <p>94. Signature of jury: <i>[Signature]</i></p>         |  |
| <p>95. Name of jury: <i>John W. Smith</i></p>         |  | <p>96. Signature of jury: <i>[Signature]</i></p>         |  |
| <p>97. Name of jury: <i>John W. Smith</i></p>         |  | <p>98. Signature of jury: <i>[Signature]</i></p>         |  |
| <p>99. Name of jury: <i>John W. Smith</i></p>         |  | <p>100. Signature of jury: <i>[Signature]</i></p>        |  |

101. Name of jury: *John W. Smith*

102. Signature of jury: *[Signature]*

103. Name of jury: *John W. Smith*

104. Signature of jury: *[Signature]*

105. Name of jury: *John W. Smith*

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199. Name of jury: *John W. Smith*

200. Signature of jury: *[Signature]*

1  
13415  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13377

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> MARYLAND   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Calvert</b> ✓                |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Crownsville</b>  |  |  |  | c. LENGTH OF STAY IN 1b<br><b>15 yrs 7 mos. 12 days</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Huntington</b> |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Crownsville State Hospital</b>   |  |  |  | d. STREET ADDRESS<br><b>Unknown</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>     |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Harry</b> Middle <b>Plater</b> Last <b>Plater</b>   |  |  |  | 4. DATE OF DEATH<br>Month <b>12</b> Day <b>7</b> Year <b>1960</b>   |  |   |  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>Negro</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>1907</b>   |  |
| 9. AGE (In years last birthday)<br><b>53</b> yrs.   |  | IF UNDER 1 YEAR<br>Months <b>53</b> Days <b>7</b> Hours <b>12</b> Min.   |  | IF UNDER 24 HRS.<br>Months <b>53</b> Days <b>7</b> Hours <b>12</b> Min.   |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Farmer</b>  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Farmer</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  |  |   |  |   |  |
| 13. FATHER'S NAME<br><b>Alexander Plater</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Marguerite Harvey</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |  |  |  | 16. SOCIAL SECURITY NO.<br><b>Unknown</b>   |  | 17. INFORMANT<br><b>Hospital Records</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b><br>DUE TO <b>025X</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Syphilitic &amp; Arteriosclerotic Cardiovascular Disease</b><br>DUE TO<br>(c) <b>General Paresis</b> |  |  |  | INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <b>02</b> p. m. <b>19</b>  |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Apr. 5, 1945</b> to <b>Dec. 7, 1960</b> , that (I) (we) last saw the deceased alive on <b>Dec. 7, 1960</b> , and that death occurred at <b>5:40 P.M.</b> from the causes and on the date stated above.   |  |  |  |   |  |   |  |
| 22a. SIGNATURE<br><i>L. Benedict</i>  |  |  |  | 22b. DATE<br><b>December 8, 1960</b>  |  |   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>L. Benedict, M. D.</b>   |  |  |  | 22d. ADDRESS<br><b>Crownsville State Hospital, Maryland</b>   |  |   |  |
| 23a. (BURIAL) CREMATION, REMOVAL (Specify)<br><b>12-10-60</b>   |  | 23b. DATE THEREOF<br><b>12-10-60</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Hope</b>   |  | 23d. LOCATION (City, town, or county) (State)<br><b>Baltimore, Md.</b>                                |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>P. E. Sewell</b>   |  |  |  | 25a. REC'D BY REGISTRAR<br><b>P. Frederick, Md.</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles E. House</b>   |  |

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1887

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

1  
13361  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13378

|  |                                  |  |   |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>                 |                                  | c. LENGTH OF STAY IN 1b<br><b>6 hours</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Anne Arundel General Hospital</b> |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Irene</b> Middle <b>QUEEN</b> Last <b>QUEEN</b>                      |                                  | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>28</b> Year <b>1960</b>   |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>Negro</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>May 12, 1911</b> |
| 9. AGE (In years last birthday)<br><b>49 yrs.</b>  |                                  | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months <b>49</b> Days <b>49</b> Hours <b>49</b> Min. <b>49</b>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired)<br><b>Chorwoman</b>      |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Gov't.</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |   |
| 13. FATHER'S NAME<br><b>Unknown</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>                                      |                                  | 16. SOCIAL SECURITY NO.<br><b>1</b>  |   |
| 17. INFORMANT<br><b>Address</b>  |                                  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Lobar Pneumonia</b><br>DUE TO <b>490X</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>490X</b> DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>7 days</b> |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                    |                                  | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                         |                                  | 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <b>19</b> p. m. <b>19</b>   |   |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>               |                                  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   |
| 20f. (City or town) (County) (State)   |                                  | 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Dec. 27, 1960</b> , to <b>Dec. 28, 1960</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Dec. 28, 1960</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above.  |   |
| 22a. SIGNATURE<br><b>James R. Martin</b>   |                                  | 22b. DATE SIGNED<br><b>12/28/60</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>James R. Martin</b>   |                                  | 22d. ADDRESS<br><b>6 Shaw St., Annapolis, Md.</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>12-31-60</b>   |                                  | 23b. DATE THEREOF<br><b>Not</b>  |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Harmony Mem. Pk.</b>  |                                  | 23d. LOCATION (City, town, or county) (State)<br><b>Highland Park Md.</b>  |   |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Henry S. Washington &amp; Sons</b>  |                                  | 25. REC'D BY REGISTRAR<br><b>4925-11-60</b>  |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>12/28/60</b>  |                                  | 25c. DATE<br><b>JAN 3 '61</b>  |   |

13838

CERTIFICATE OF DEATH

13861

Blank certificate form with horizontal lines for text entry. Includes a circular stamp on the right side.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

13362

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13379

|   |                        |  |                                |
|---|------------------------|--|--------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY Anne A undel MARYLAND  |                        | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Maryland b. COUNTY Anne Arundel                        |                                |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis  |                        | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis  |                                |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital  |                        | d. STREET ADDRESS 176 Larkin St.,  |                                |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                        |  |                                |
| 3. NAME OF DECEASED (Type or print) First Middle Last William Thomas QUEEN  |                        | 4. DATE OF DEATH Month Day Year December 26 19 60  |                                |
| 5. SEX Male   | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 2 - 1887 |
| 9. AGE (In years last birthday) 73 yrs.   |                        | IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.  |                                |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer -- City of Annapolis  |                        | 10b. KIND OF BUSINESS OR INDUSTRY Maryland   |                                |
| 11. BIRTHPLACE (State or foreign country) Maryland  |                        | 12. CITIZEN OF WHAT COUNTRY? U.S.A.  |                                |
| 13. FATHER'S NAME Elijah Queen  |                        | 14. MOTHER'S MAIDEN NAME Lovy Woodhouse  |                                |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No   |                        | 16. SOCIAL SECURITY NO. 214-05-1192A   |                                |
| 17. INFORMANT Adele Parker - 405 Oaklawn Ave. Anna. Md.   |                        | Address  |                                |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 443 X Cerebral Hemorrhage<br>DUE TO (b) Hypertensive Arteriosclerosis / Heart Disease<br>DUE TO (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1 day 1 mo |                        | INTERVAL BETWEEN ONSET AND DEATH   |                                |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                        | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                        | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19  |                        | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                        | 20f. (City or town) (County) (State)   |                                |
| 21. I certify that (I) (the hospital) attended the deceased from Dec. 19, 19 60, to Dec. 25, 19 60, that (I) (we) lost the deceased alive on Dec. 25, 19 60, and that death occurred at M. from the causes and on the date stated above.  |                        |  |                                |
| 22a. SIGNATURE James R. Martin  |                        | 22b. DATE SIGNED 12/27/60  |                                |
| 22c. PHYSICIAN'S NAME (Type) James R. Martin  |                        | 22d. ADDRESS 6 Shaw St., Annapolis, Md.  |                                |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial  |                        | 23b. DATE THEREOF 12-29-60   |                                |
| 23c. NAME OF CEMETERY OR CREMATORY Brewer Hill  |                        | 23d. LOCATION (City, town, or county) (State) Annapolis, Md.   |                                |
| 24. FUNERAL DIRECTOR'S SIGNATURE C.E. Hicks III   |                        | ADDRESS Annapolis, Maryland  |                                |
| 25a. REC'D BY REGISTRAR JAN 4 '61   |                        | 25b. REGISTRAR'S SIGNATURE Arthur L. Hanes   |                                |



13363

CERTIFICATE OF DEATH

Reg. Dist. No.

13380

|  |                               |  |                                      |   |  |  |  |
|--|-------------------------------|--|--------------------------------------|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Anne Arundel</u> MARYLAND  |                               |  |                                      | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>  |                               |  |                                      | c. LENGTH OF STAY IN 1b   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5 Revell St.</u>   |                               |  |                                      | d. STREET ADDRESS <u>5 Revell St</u> 1  |  |  |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                               |  |                                      |   |  |  |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>HENRY DENISON RANDALL</u>   |                               |  |                                      | 4. DATE OF DEATH Month Day Year <u>DEC 7 1960</u>   |  |  |  |
| 5. SEX <u>MALE</u>   | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>JULY 20 1881</u> | 9. AGE (In years last birthday) <u>79</u> yrs.  | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALES MANAGER (RET.) GEN. ELECTRIC</u>  |                               |  |                                      | 10b. KIND OF BUSINESS OR INDUSTRY <u>LEDYARD CONN</u>   |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>                             |  |
| 13. FATHER'S NAME <u>JASON L. RANDALL</u>  |                               |  |                                      | 14. MOTHER'S MAIDEN NAME <u>HENRIETTA A. STODDARD</u>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)  |                               |  |                                      | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT Address <u>HENRY D. RANDALL JR #2</u>                    |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>331 X Embolic accident &amp; Rt. Hemiparesis</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypostatic pneumonia</u><br>DUE TO (c) <u></u> |                               |  |                                      |   |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>6 wks.</u>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>  |                               |  |                                      |   |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               |  |                                      | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>   |                               |  |                                      | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                       |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  |
|  |                               |  |                                      | 20f. (City or town) (County) (State)  |  |  |  |
| 21. I certify that I attended the deceased from <u>October</u> , 19 <u>60</u> , to <u>December</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Dec. 6</u> , 19 <u>60</u> , and that death occurred at <u>12:45</u> M., from the causes and on the date stated above.   |                               |  |                                      |   |  |  |  |
| ACTUAL SIGNATURE <u>John Hedeman</u>   |                               |  |                                      | ADDRESS (Street, city or town, state) <u>121 CATHEDRAL ST. ANNAPOLIS MD.</u>  |  |  |  |
| PHYSICIAN'S NAME (Type) <u>JOHN HEDEMAN</u>  |                               |  |                                      | DATE SIGNED <u>12/8/60</u>  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>  |                               | 22b. DATE THEREOF <u>12-10-60</u>  |                                      | 22c. NAME OF CEMETERY OR CREMATORY <u>Ledyard Center</u>  |  | 22d. LOCATION (City, town, or county) (State) <u>Ledyard Conn.</u>     |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>JOHN M. TAYLOR-SONS ANNAPOLIS MD</u>   |                               |  |                                      | 24a. REC'D BY REGISTRAR DATE <u>DEC 9 '60</u>   |  | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kirsch</u>                     |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1936

Page One

|   |  |   |  |
|---|--|---|--|
| <p>1. Name of deceased: <u>John Doe</u></p>             |  | <p>2. Sex: <u>Male</u></p>                                  |  |
| <p>3. Date of birth: <u>Jan 1, 1900</u></p>             |  | <p>4. Age: <u>36</u></p>                                    |  |
| <p>5. Date of death: <u>Dec 15, 1936</u></p>            |  | <p>6. Time of death: <u>10:00 AM</u></p>                    |  |
| <p>7. Place of death: <u>Home</u></p>                   |  | <p>8. Cause of death: <u>Heart Disease</u></p>              |  |
| <p>9. Immediate cause: <u>Myocardial Infarction</u></p> |  | <p>10. Underlying cause: <u>Coronary Artery Disease</u></p> |  |
| <p>11. Contributing cause: <u>None</u></p>              |  | <p>12. Manner of death: <u>Natural</u></p>                  |  |
| <p>13. Signature of physician: <u>[Signature]</u></p>   |  | <p>14. Signature of registrar: <u>[Signature]</u></p>       |  |
| <p>15. Date of registration: <u>Dec 16, 1936</u></p>    |  | <p>16. Place of registration: <u>Baltimore</u></p>          |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

13416  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13381

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Anne Arundel</u> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>          |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville RFD-</u>   |  |   |  | c. LENGTH OF STAY IN 1b <u>2 1/2 yrs.</u>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Foxwell Road, Elvaton</u>   |  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>R.</u> Last <u>Riddick</u>   |  |   |  | 4. DATE OF DEATH Month <u>Dec.</u> Day <u>4</u> Year <u>1960</u>   |  |  |  |
| 5. SEX <u>Male</u>  |  | 6. COLOR OR RACE <u>White</u>                       |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>10<sup>th</sup> Jan 1874</u> |  |
| 9. AGE (In years last birthday) <u>86</u> yrs.  |  | 10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> |  | 11. IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>       |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dentist (Ret.)</u>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Self-Employed</u>   |  |  |  |
| 11. BIRTHPLACE (State or foreign country) <u>Gatesville, N. Carolina</u>  |  |   |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |  |  |
| 13. FATHER'S NAME <u>Rufus M. Riddick, Sr.</u>  |  |   |  | 14. MOTHER'S MAIDEN NAME <u>Margaret Roberts</u>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>  |  |   |  | 16. SOCIAL SECURITY NO. <u>None</u>  |  |  |  |
| 17. INFORMANT <u>Mr. William Riddick</u>  |  |   |  | Address <u>P.O. Box 17, Glen Burnie, Md.</u>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u><br>4344 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Heart Failure</u><br>DUE TO<br>(c) <u>  </u> |  |   |  | INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u><br><u>1 month</u>   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Carcinoma Colon</u>   |  |   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. 19<br>p. m.  |  |   |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |   |  | 20f. (City or town) (County) (State)   |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>December 1956</u> to <u>December 1960</u> , that (I) (we) last saw the deceased alive on <u>Dec 3</u> 19 <u>60</u> , and that death occurred at <u>4:30</u> M, from the causes and on the date stated above.   |  |   |  |  |  |  |  |
| 22a. SIGNATURE <u>C. McDonald MD</u>  |  |   |  | 22b. DATE SIGNED <u>12-4-60</u>  |  |  |  |
| 22c. PHYSICIAN'S NAME (Type)  |  |   |  | 22d. ADDRESS   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |  |   |  | 23b. DATE THEREOF <u>24 Dec. 1960</u>  |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Ayden Cemetery</u>  |  |   |  | 23d. LOCATION (City, town, or county) (State) <u>Ayden, N. Carolina</u>  |  |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Richard V. Singleton</u>  |  |   |  | 25a. REC'D BY REGISTRAR <u>Glen Burnie, Md.</u>  |  |  |  |
| 25b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>   |  |   |  | DATE <u>DEC 6 '60</u>  |  |  |  |

13416

CERTIFICATE OF DEATH

13381

I, the undersigned, being a duly qualified Medical Officer of Health for the City and County of New York, do hereby certify that  
 the within and foregoing is a true and correct copy of the original record of the death of  
**Charles J. Ricks**  
 Male  
 Date of Birth **Sept. 18, 1864**  
 Date of Death **Sept. 18, 1904**  
 Place of Birth **St. Louis, Mo.**  
 Cause of Death **Heart Disease**  
 Signed at New York, N.Y., this **19th** day of **September**, 1904.  
 \_\_\_\_\_  
 Medical Officer of Health

Attest:  
 \_\_\_\_\_  
 City Clerk

1  
 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

13364

13382

|  |                                  |  |  |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>          |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>3 hours</b>  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>RURAL - Gambrills</b> |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Anne Arundel General Hospital</b>   |                                  | e. d. STREET ADDRESS<br><b>1</b>   | e. IS RESIDENCE ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>RIDGLEY</b>   |                                  | 4. DATE OF DEATH<br>Month Day Year<br><b>December 31 19 60</b>   |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>Negro</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Dec. 31, 1960</b>   |
| 9. AGE (In years last birthday)<br><b>3</b>  |                                  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.<br><b>3 10</b>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Maryland</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>U.S.</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |  |
| 13. FATHER'S NAME<br><b>James Ridgley</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Alice Ridgley</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)   |                                  | 16. SOCIAL SECURITY NO.<br><b>Alice Ridgley Gambrills Md.</b>  |  |
| 17. INFORMANT<br><b>Alice Ridgley Gambrills Md.</b>  |                                  | Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Prematurity</b><br>DUE TO <b>776X</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b)<br>DUE TO<br>(c)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>3 hrs 10 min</b> |                                  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m.<br>19   |                                  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (the hospital) attended the deceased from <b>Dec. 31, 19 60</b> to <b>Dec. 31, 19 60</b> , that (I) (we) last saw the deceased alive on <b>Dec. 31, 19 60</b> , and that death occurred at <b>8:50 P.M.</b> from the causes and on the date stated above.   |                                  |  |  |
| 22a. SIGNATURE<br><b>James W. Hayes</b> M.D.   |                                  | 22b. DATE SIGNED<br><b>8:50 P.M.</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>James W. Hayes</b>  |                                  | 22d. ADDRESS<br><b>Medical Bldg., Severna Park, Md.</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>1-7-1961</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Nelsons Removal</b>   |                                  | 23d. LOCATION (City, town, or county) (State)<br><b>Gambrills Md.</b>  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>William Reese</b>   |                                  | 25a. REC'D BY REGISTRAR<br><b>Arthur L. Kline</b>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Kline</b>   |                                  | DATE<br><b>JAN 9 '61</b>   |  |

2063 35V XV0

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

1888



89

13365

13383

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

|  |                                  |   |  |   |   |   |   |
|--|----------------------------------|---|--|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>A.A.Co. Annapolis, Md</u> MARYLAND   |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> |   |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>ANNAPO LIS, Md.</u>   |                                  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>60 Glen Burnie</u>                                       |   |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Anne Arundel Gen. Hospital</u>  |                                  |   |  | d. STREET ADDRESS<br><u>1541 Tieman Drive</u>   |   |   |   |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |   |  |   |   |   |   |
| 3. NAME OF DECEASED<br>(Type or print) <u>Isabell</u>  |                                  | First <u>M</u> Middle <u>R</u> Last <u>Roane</u>  |  | 4. DATE OF DEATH<br>Month <u>12</u> Day <u>25</u> Year <u>1960</u>  |   |   |   |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>15 Sept. 1891</u> |   | 9. AGE (In years lost birthday)<br><u>69</u> yrs. | 10. IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Packet (ref.)</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Noxema Corp.</u>  |  | 11. BIRTHPLACE (State or foreign country)<br><u>Farguer Co., Va.</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |   |
| 13. FATHER'S NAME<br><u>(Unknown) Alexander</u>  |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Cora J. Thompson</u>   |   |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <u>No</u>  |                                  | 16. SOCIAL SECURITY NO.<br><u>215-03-4225</u>   |  | 17. INFORMANT<br><u>Mrs. Grace E. Carey</u>   |   | Address<br><u>Same As #2</u>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Uremic coma</u><br>550.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Hypertensive arterio-sclerotic C.-V. Disease</u> 10 yrs<br>(c) <u>Acute appendicitis, perforated, gen. peritonitis</u> 28 days |                                  |   |  |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>4 days</u>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Duodenal Ulcer, chronic. Chronic generalized arthritis</u>   |                                  |   |  |   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |   |   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br><u>19</u>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 28, 1960</u> to <u>Dec. 25, 1960</u> , that (I) (we) last saw the deceased alive on <u>Dec. 25, 1960</u> , and that death occurred at <u>1:40 P.M.</u> from the causes and on the date stated above.   |                                  |   |  |   |   |   |   |
| 22a. SIGNATURE<br><u>Merton T. Waite</u>   |                                  |   |  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>            |   | 22b. DATE SIGNED<br><u>12/25/60</u>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>MERTON T. Waite</u>   |                                  |   |  | 22d. ADDRESS<br><u>121 Cathedral St., Annapolis, Md.</u>  |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                                  | 23b. DATE THEREOF<br><u>28th Dec. 1960</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Woodlawn Cem.</u>  |   | 23d. LOCATION (City, town, or county) (State)<br><u>Woodlawn, Md.</u>                 |   |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><u>W. Singleton</u>  |                                  |   |  | ADDRESS<br><u>Glen Burnie, Md.</u>  |   | 25a. REC'D BY REGISTRAR<br>DATE <u>DEC 29 '60</u>                                     |   |
|  |                                  |   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Krawe</u>  |   |   |   |

BP

13282

CENTRAL DEPT.

1. The first part of the report is a general statement of the work done during the year. It is a summary of the work done by the various departments and is intended to give a general idea of the work done during the year.

2. The second part of the report is a detailed statement of the work done during the year. It is a summary of the work done by the various departments and is intended to give a general idea of the work done during the year.

3. The third part of the report is a detailed statement of the work done during the year. It is a summary of the work done by the various departments and is intended to give a general idea of the work done during the year.

4. The fourth part of the report is a detailed statement of the work done during the year. It is a summary of the work done by the various departments and is intended to give a general idea of the work done during the year.

5. The fifth part of the report is a detailed statement of the work done during the year. It is a summary of the work done by the various departments and is intended to give a general idea of the work done during the year.

6. The sixth part of the report is a detailed statement of the work done during the year. It is a summary of the work done by the various departments and is intended to give a general idea of the work done during the year.

7. The seventh part of the report is a detailed statement of the work done during the year. It is a summary of the work done by the various departments and is intended to give a general idea of the work done during the year.

8. The eighth part of the report is a detailed statement of the work done during the year. It is a summary of the work done by the various departments and is intended to give a general idea of the work done during the year.

9. The ninth part of the report is a detailed statement of the work done during the year. It is a summary of the work done by the various departments and is intended to give a general idea of the work done during the year.

10. The tenth part of the report is a detailed statement of the work done during the year. It is a summary of the work done by the various departments and is intended to give a general idea of the work done during the year.



may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**

13417

**CERTIFICATE OF DEATH**

Items 11, 12, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

13384

|   |  |   |  |   |  |  |  |   |  |
|---|--|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Anne Arundel</b>   |  | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Glen Burnie</b>    |  | c. LENGTH OF STAY IN 1b<br><b>5 1/2 Months</b>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Maryland</b> |  | b. COUNTY<br><b>3V01-4</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Plaza Manor Nursing Home</b>   |  |   |  | d. STREET ADDRESS<br><b>1300 W. Baltimore Street 23</b>   |  |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br><b>Irene Robinson</b>  |  | First<br><b>Irene</b>   |  | Middle<br><b>Robinson</b>   |  | Last   |  | 4. DATE OF DEATH<br>Month<br><b>December 23,</b><br>Day<br><b>1960</b>                            |  |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>10/</b><br><b>September 1883</b>  |  | 9. AGE (In years last birthday)<br><b>77</b> yrs.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Unknown Housewife</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Unknown ?</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>Unknown U.S.A.</b>  |  |   |  |
| 13. FATHER'S NAME<br><b>Unknown Thomas A. Kelly</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Unknown IRENE E. Christmas</b>   |  |  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |  | 17. INFORMANT<br><b>Mrs. Rainey-B.C.D.P.W.</b>  |  | Address  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b><br><b>420.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last.<br>(b) _____ DUE TO<br>(c) _____ |  |   |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Unknown</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Seizure disorder</b>  |  |   |  |   |  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |   |  |  |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. _____<br>p. m. _____<br><b>19</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town)<br><b>1</b>  |  | (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>7-8-1960</b> to <b>12-23</b> , 1960, that (I) (we) lost saw the deceased alive on <b>12-3-1960</b> , and that death occurred at <b>8:15</b> A. M. from the causes and on the date stated above.  |  |   |  |   |  |  |  |   |  |
| 22a. SIGNATURE<br><b>James M. Pair</b>  |  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>  |  | MED. DIRECTOR <input type="checkbox"/>  |  | STAFF PHYS. <input type="checkbox"/>   |  | 22b. DATE SIGNED<br><b>12-23-1960</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>James M. Pair, M.D.</b>  |  | 22d. ADDRESS<br><b>400 N. Carrollton Avenue Balto. 23, Md.</b>  |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 23b. DATE THEREOF   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Pk. Cem.</b>  |  | 23d. LOCATION (City, town, or county) (State)<br><b>FREDERICK AVE. Balto. Md.</b>                                    |  |   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Joseph N. Zeman Jr.</b>  |  |   |  | ADDRESS<br><b>312 S. Highland.</b>  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>DEC 27 '60</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony S. Kraus</b>   |  |

may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



13418

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MARYLAND</b>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>          |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arnold</b>   |  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arnold</b>   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deep Creek Rd.</b>   |  |   |  | d. STREET ADDRESS <b>1 Deep Creek Rd.</b>  |  |   |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |  |  |   |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last <b>AMY LEE ROSS</b>  |  |   |  | 4. DATE OF DEATH Month Day Year <b>DECEMBER 11 1960 19 60</b>  |  |   |  |
| 5. SEX <b>Female</b>   |  | 6. COLOR OR RACE <b>White</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>Oct. 29, 1958</b>                                 |  |
| 9. AGE (In years lost birthday) <b>2</b> yrs.  |  | 10. IF UNDER 1 YEAR Months Days Hours Min.  |  | 11. BIRTHPLACE (State or foreign country) <b>Annapolis, Maryland</b>   |  | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>                               |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>  |  |   |  |
| 13. FATHER'S NAME <b>Robert B. Ross</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME <b>Madolin Moreland</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>   |  | 16. SOCIAL SECURITY NO. <b>none</b>   |  | 17. INFORMANT Address <b>Mr. Robert B. Ross Father same as # 2</b>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br><b>752X</b> IMMEDIATE CAUSE (a) <b>Hydrocephalus and Myelomeningocele</b><br>DUE TO (b) <b>Genetic Abnormalities -</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  |   |  |  |  |   | INTERVAL BETWEEN ONSET AND DEATH <b>BIRTH</b>  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  |  |  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                                  |  |
| 21. I certify that I attended the deceased from <b>10/29</b> , 19 <b>58</b> , to <b>12/11</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>12/8</b> , 19 <b>60</b> , and that death occurred at <b>M.</b> , from the causes and on the date stated above.   |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE <b>Philip Briscoe</b>   |  |   |  | ADDRESS (Street, city or town, state) <b>95 Calverton St Annapolis, Maryland</b>   |  |   |  |
| DATE <b>12/15/60</b>   |  |   |  | DATE SIGNED <b>12/15/60</b>  |  |   |  |
| PHYSICIAN'S NAME (Type) <b>Philip Briscoe MD.</b>  |  |   |  | Ann Arbor, Michigan  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  | 22b. DATE THEREOF <b>12-16-60</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY <b>Asbury Methodist Cemetery</b>  |  | 22d. LOCATION (City, town, or county) (State) <b>Arnold, Maryland</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping Funeral Home</b>   |  |   |  | ADDRESS <b>Annapolis, Md.</b>  |  |   |  |
| 24a. REC'D BY REGISTRAR <b>DEC 19 1960</b>   |  |   |  | 24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>  |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
15M 9/59

1  
13366  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13386

|  |                                  |   |                                      |
|--|----------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>             |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Edgewater</b>  |                                      |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Anne Arundel General Hospital</b>   |                                  | d. STREET ADDRESS<br><b>R. F. D.</b>  |                                      |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |   |                                      |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Herbert</b> Middle <b>C.</b> Last <b>Runyan</b>  |                                  | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>16</b> Year <b>1960</b>  |                                      |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br><b>1-12-1895</b> |
| 9. AGE (In years last birthday)<br><b>65</b> yrs.  |                                  | IF UNDER 1 YEAR<br>Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>               |                                      |
| IF UNDER 24 HRS.<br>Hours <input type="checkbox"/> Min. <input type="checkbox"/>   |                                  |   |                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Auto Mechanic</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Ret.</b>  |                                      |
| 11. BIRTHPLACE (State or foreign country)<br><b>Texas</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |                                      |
| 13. FATHER'S NAME<br><b>Isaac J. Runyan</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>  |                                      |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>-</b>   |                                      |
| 17. INFORMANT<br><b>Arthur J. Runyan</b>   |                                  | Address<br><b>(2)</b>   |                                      |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hepatic failure</b><br>DUE TO <b>581.1</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Cirrhosis of the Liver (Laennec's)</b><br>DUE TO<br>(c) |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 month</b><br><b>5 years</b>  |                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>None</b>   |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                      |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                      |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |                                      |
| 21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>10/31</b> , 19 <b>60</b> , to <b>12/16</b> , 19 <b>60</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>12/16</b> , 19 <b>60</b> , and that death occurred at <b>7P.</b> M, from the causes and on the date stated above.                       |                                  |   |                                      |
| 22a. SIGNATURE<br><b>Richard L. Hockman</b>  |                                  | 22b. DATE SIGNED  |                                      |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Dr. R. I. Hockman</b>   |                                  | 22d. ADDRESS<br><b>100 Cathedral St., Annapolis, Md.</b>  |                                      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>Dec 20-1960</b>   |                                      |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Hillcrest Cemt</b>  |                                  | 23d. LOCATION (City, town, or county) (State)<br><b>Annapolis Md</b>  |                                      |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>John M. Taylor Sons</b>   |                                  | 25a. REC'D BY REGISTRAR<br>DATE <b>DEC 23 '60</b>   |                                      |
| 25b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>   |                                  |   |                                      |

13886

CERTIFICATE OF DEATH

13886

John Arnold  
Maryland  
Edgewater

John Arnold  
Annapolis

John Arnold General Hospital

Harbert C. Ryan December 18 50

Male White

(2)

100 Cathedral St., Annapolis, Md.

Dr. F. J. Lockman



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |  |   |  |  |   |  |  |
|--|--|--|--|--|--|---|--|--|---|--|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |  |  |  |  |   |  |  |   |  |  |
| 13367 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13387  |  |  |  |  |  |   |  |  |   |  |  |
| Item 8 Film 6277 12-20-60 et   |  |  |  |  |  |   |  |  |   |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b><br>c. LENGTH OF STAY IN 1b <b>MARYLAND</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Anne Arundel General Hospital</b>  |  |  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Baltimore</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b><br>d. STREET ADDRESS <b>3451 Park Heights Avenue</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |   |  |  |
| 3. NAME OF DECEASED (Type or print) <b>MEYER</b>   |  |  | 4. DATE OF DEATH <b>December 12 1960</b>   |  |  | 5. SEX <b>Male</b>  |  |  | 6. COLOR OR RACE <b>White</b>   |  |  |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  | 8. DATE OF BIRTH <b>Oct. 5, 1915</b>   |  |  | 9. AGE (in years last birthday) <b>45</b> yrs.  |  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>T.Y. Repair</b> |  |  |
| 11. BIRTHPLACE (State or foreign country) <b>Baltimore Md</b>  |  |  | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |  | 13. FATHER'S NAME <b>Isaac</b>  |  |  | 14. MOTHER'S MAIDEN NAME <b>Jennie</b>  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>  |  |  | 16. SOCIAL SECURITY NO. <b>1-11-60</b>   |  |  | 17. INFORMANT <b>Helw Sacks</b>   |  |  | Address <b>same</b>   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Drowning.</b><br>851X DUE TO<br>Conditions, if any, which gave rise to immediate cause (b)<br>(c) DUE TO (e), stating the underlying cause last.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)<br>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |   |  |  |   |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  |  | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.)<br><b>Boat sunk.</b>   |  |  |   |  |  |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <b>XX</b> <b>12/12/60</b> p.m.  |  |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> |  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Chesapeake Bay</b>  |  |  | 20f. (City or town) (County) (State)<br><b>Off Annapolis A.A. Md.</b>   |  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  |  |  |  |  |  |   |  |  |   |  |  |
| ACTUAL SIGNATURE <b>Charles S. Petty</b>   |  |  | M.D. <b>Charles S. Petty, M.D.</b>   |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |  | DATE SIGNED <b>12/13/60</b>   |  |  |
| EXAMINER'S NAME (Type) <b>Charles S. Petty, M.D.</b>   |  |  | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>   |  |  | Address (Street, city, town, or county)   |  |  |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  |  | 22b. DATE THEREOF <b>12-15-60</b>  |  |  | 22c. NAME OF CEMETERY OR CREMATORY <b>Mt Carmel</b>   |  |  | 22d. LOCATION (City, town, or country) (State)<br><b>Balto Md</b>   |  |  |
| 23. FUNERAL DIRECTOR <b>Jack Lewinke</b>   |  |  | ADDRESS <b>2100 Euterpe Pl</b>   |  |  | 24a. REC'D BY REGISTRAR <b>DEC 16 '60</b>   |  |  | 24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>   |  |  |

52

*Maryland*

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CHEN'S

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
ISM 9/59

13419

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13388

|   |                                  |  |  |  |   |   |                                |
|---|----------------------------------|--|--|--|---|---|--------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>  |                                  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> |   |   |                                |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Crownsville</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>2 years</b><br><b>11 mo. 5 days</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><b>Crownsville State Hospital</b>  |                                  |  |  | d. STREET ADDRESS<br><b>521 Bethel Street</b>  |   |   |                                |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Edward</b> Middle <b>Chambers</b> Last <b>Sander</b>   |                                  |  |  | 4. DATE OF DEATH<br>Month <b>12</b> Day <b>7</b> Year <b>1960</b>  |   |   |                                |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>Negro</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br><b>Separated</b><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>March 4, 1877</b> |  | 9. AGE (In years last birthday)<br><b>83</b> yrs. | IF UNDER 1 YEAR<br>Months Days Hours Min.   | IF UNDER 24 HRS.<br>Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br>-----   |  | 11. BIRTHPLACE (State or foreign country)<br><b>North Carolina</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                                |
| 13. FATHER'S NAME<br><b>Joseph Chambers</b>   |                                  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Maggie Robinson</b>   |   |   |                                |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>Yes-Spanish-American</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>Unknown</b>  |  | 17. INFORMANT<br><b>Hospital Records</b>   |   | Address   |                                |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b><br><b>422.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO<br>(c) DUE TO<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                  |  |  |  |   | INTERVAL BETWEEN ONSET AND DEATH  |                                |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>-----  |  |  |   |   |                                |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. ----- 19   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>-----  |   | 20f. (City or town) (County) (State)  |                                |
| 21. I certify that (I) (this hospital) attended the deceased from <b>7/9</b> <b>1957</b> , to <b>12/7</b> <b>1960</b> , that (I) (we) last saw the deceased alive on <b>12/7</b> <b>1960</b> , and that death occurred at <b>10A</b> <b>M</b> , from the causes and on the date stated above.   |                                  |  |  |  |   |   |                                |
| 22a. SIGNATURE<br><i>[Signature]</i>  |                                  |  |  | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>         |   | 22b. DATE<br><b>12/7/60</b>   |                                |
| 22c. PHYSICIAN'S NAME (Type)<br><b>L. Benedict, M. D.</b>   |                                  |  |  | 22d. ADDRESS<br><b>Crownsville State Hospital, Md.</b>   |   |   |                                |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>12-10-60</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Calvary</b>   |   | 23d. LOCATION (City, town, or county) (State)<br><b>a. a. County, Md</b>                          |                                |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><i>Joseph B. Locks Jr.</i>  |                                  |  |  | ADDRESS<br><b>1304 N. Central Ave.</b>   |   | 25a. REC'D BY REGISTRAR<br><b>DEC 9 '60</b>   |                                |
|   |                                  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Arthur L. Hume</i>  |   |   |                                |



13878

OFFICE OF THE SECRETARY OF DEFENSE

13878



CHIEF, JAVH



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

V5 A15 (4)  
15M 10/57

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
13420  
CERTIFICATE OF DEATH

13389

Reg. Dist. No.

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>ANNE ARUNDEL</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>RIVA</b><br>c. LENGTH OF STAY IN lb<br><b>RIVA</b><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>RIVA GUEST HOUSE</b>  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>MARYLAND</b><br>b. COUNTY<br><b>ANNE ARUNDEL</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>RIVA</b><br>d. STREET ADDRESS<br><b>1 NONE</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>ANNA SAULIT</b>   |                                  | 4. DATE OF DEATH<br>Month Day Year<br><b>DECEMBER 10 19 60</b>  |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. <del>MARRIED</del> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>May 5, 1887</b> |
| 9. AGE (In years last birthday)<br><b>73 yrs.</b>  |                                  | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>House wife</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>own home</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Latvia</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>Michael Bihnatt</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>none</b>  |  |
| 17. INFORMANT<br><b>Mr John E. Saulit</b>  |                                  | Address<br><b>Son Same as # 2</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br><b>174X</b> IMMEDIATE CAUSE (a) <b>Ceramics of the uterus</b><br>DUE TO (b) <b>Metastasis to Intestine Tract</b><br>DUE TO (c) <b>Liver</b><br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 yrs.</b><br><b>6 months.</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Arteriosclerosis - Cardio Vascular Disease</b>  |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, agency, street, office bldg., etc.)<br><b>Home</b>   |                                  | 20f. (City or town) (County) (State)<br><b>Ann. 10, 1960</b>  |  |
| 21. I certify that I attended the deceased from <b>Dec 10, 1960</b> to <b>Dec 10, 1960</b> that I last saw the deceased alive on <b>Dec 10, 1960</b> , and that death occurred at <b>9:30 P.M.</b> from the causes and on the date stated above.   |                                  | ADDRESS (Street, city or town, state)<br><b>Southgate Ave, Annapolis, Maryland</b>  |  |
| ACTUAL SIGNATURE<br><b>Albert L. Anderson</b><br>M.D.  |                                  | DATE SIGNED<br><b>12/14/60</b>  |  |
| PHYSICIAN'S NAME (Type)<br><b>Albert L. Anderson MD.</b>   |                                  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>Dec. 16 - 1960</b>  |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>All Hallowes Cemetery</b>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Davidsonville, Md.</b>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Hopping Funeral Home</b><br>ADDRESS<br><b>Annapolis, Md.</b>  |                                  | 24a. REC'D BY REGISTRAR<br>DATE<br><b>DEC 19 '60</b>  |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Knead</b>   |                                  |   |  |





13421  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
Items 1, 2, Film 0278 1-5-61 et 3V014

13390

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Anne Arundel</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u><br>c. LENGTH OF STAY IN 1b <u>3 Mos. 6 days</u><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State</u>   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Md.</u><br>b. COUNTY <u>Anne Arundel</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville, Md.</u><br>d. STREET ADDRESS <u>3316 Anchenbury Ter.</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>John</u> Middle <u>W</u> Last <u>Saunders</u>  |   | 4. DATE OF DEATH<br>Month <u>12</u> Day <u>24</u> Year <u>1960</u>  |   |
| 5. SEX <u>M</u>  | 6. COLOR OR RACE <u>Negro</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH <u>12-24-77</u>                          |
| 9. AGE (In years and birthday) <u>83</u>   |   | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>waiter</u>  | 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |   | 13. FATHER'S NAME <u>Richard Gray</u>   |   |
| 14. MOTHER'S MAIDEN NAME   |   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)   |   |
| 16. SOCIAL SECURITY NO.  |   | 17. INFORMANT <u>medical Record</u> Address <u>Crownsville, Md</u>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac &amp; Respiratory failure</u><br>DUE TO (b) <u>Extreme old age</u><br>DUE TO (c) <u>Since Admission</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. |   | INTERVAL BETWEEN ONSET AND DEATH <u>5-10 hrs</u>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CHRONIC BRAIN SYNDROME ASSOCIATED TO GENERALIZED ARTERIOSCLEROSIS</u>   |   |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br><u>19</u>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                      |
| 21. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.  |   |   |   |
| 22a. SIGNATURE <u>L. Benedict M.D.</u>   |   | 22b. DATE SIGNED  |   |
| 22c. PHYSICIAN'S NAME (Type) <u>L. BENEDICT M.D.</u>   |   | 22d. ADDRESS <u>CROWNSSVILLE STATE HOSPITAL</u>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  | 23b. DATE THEREOF <u>12-28-60</u>   | 23c. NAME OF CEMETERY OR CREMATORY <u>Arbutus</u>   | 23d. LOCATION (City, town, or county) (State) <u>Md</u>   |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Geo. S. Nelson</u> ADDRESS <u>1348 N. Calhoun St</u>   |   | 25a. REC'D BY REGISTRAR DATE <u>DEC 27 '60</u>  |   |
|  |   | 25b. REGISTRAR'S SIGNATURE <u>W. S. Thorne</u>  |   |

MEDICAL CERTIFICATION

1850

1851

1852

*[Faint, illegible text, likely bleed-through from the reverse side of the page]*

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4 Film G276 12-9-60 et

13422

## CERTIFICATE OF DEATH

Reg. Dist. No.

13391

|   |  |  |  |   |  |  |   |
|---|--|--|--|---|--|--|---|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>A.A. Co.</u> <b>MARYLAND</b>   |  |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>A.A. Co.</u>                            |  |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Shipley, Maryland</u>  |  |  |  | c. LENGTH OF STAY IN 1b<br><u>Shipley</u>   |  |  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |  |  |  | d. STREET ADDRESS<br><u>Shipley Farm</u><br><u>Fairmount Road</u>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                  |   |
| <b>3. NAME OF DECEASED</b> (Type or print)<br>First Middle Last<br><u>Irene</u> <u>Amanda</u> <u>Shipley</u>  |  |  |  | <b>4. DATE OF DEATH</b><br>Month Day Year<br><u>December</u> <u>2</u> , <u>19</u> <u>60</u>   |  |  |   |
| <b>5. SEX</b><br><u>Female</u>  |  | <b>6. COLOR OR RACE</b><br><u>White</u>  |  | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> |  | <b>8. DATE OF BIRTH</b><br><u>July 4, 1875</u>   |   |
| <b>9. AGE</b> (In years last birthday)<br><u>85</u> yrs.  |  | <b>IF UNDER 1 YEAR</b><br>Months Days Hours Min.   |  | <b>IF UNDER 24 HRS.</b><br>Months Days Hours Min.   |  | <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>Retired Schoolteacher</u> |   |
| <b>10b. KIND OF BUSINESS OR INDUSTRY</b>  |  | <b>11. BIRTHPLACE</b> (State or foreign country)<br><u>Shipley, Maryland</u>                                     |  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>U.S.A.</u>  |  |  |   |
| <b>13. FATHER'S NAME</b><br><u>Richard Luther Shipley</u>   |  |  |  | <b>14. MOTHER'S MAIDEN NAME</b><br><u>Annie S. Linthicum</u>  |  |  |   |
| <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b><br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u>  |  | <b>16. SOCIAL SECURITY NO.</b><br><u>None</u>  |  | <b>17. INFORMANT</b><br><u>Mrs. J. Clinton Roberts</u>  |  | Address <u>Fairmount Road</u><br><u>Shipley, Maryland</u>  |   |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u><br><u>422.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Vascular Disease</u><br>DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____   |  |  |  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 week</u><br><u>5 years</u>                                 |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  |   |  |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a. m. p. m. _____ 19____  |  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)   |  | <b>20f. (City or town)</b> (County) (State)  |   |
| <b>21. I certify</b> that I attended the deceased from _____, 19 <u>55</u> , to _____, 19 <u>60</u> , that I last saw the deceased alive on <u>12/2/60</u> , 19____, and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) _____ DATE SIGNED _____<br>ACTUAL SIGNATURE <u>James S. Beilingh</u> M.D. <u>101 Cedar St</u> <u>Shipley, Md</u><br>PHYSICIAN'S NAME (Type) <u>James S. Beilingh</u> <u>101 Cedar St</u> <u>Shipley, Md</u> <u>Dec 5, 1960</u> |  |  |  |   |  |  |   |
| <b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br><u>Burial</u>   |  | <b>22b. DATE THEREOF</b><br><u>12/5/60</u>   |  | <b>22c. NAME OF CEMETERY OR CREMATORY</b><br><u>Loudon Park Cemetery</u>  |  | <b>22d. LOCATION</b> (City, town, or county) (State)<br><u>Baltimore, Maryland</u>   |   |
| <b>23. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>Wm. Pickner, Inc</u>  |  |  |  | <b>ADDRESS</b><br><u>Balto 17 Md</u>  |  | <b>24a. REC'D BY REGISTRAR</b><br>DATE <u>DEC 6 '60</u>  |   |
|   |  |  |  | <b>24b. REGISTRAR'S SIGNATURE</b><br><u>Charles S. Kneass</u>   |  |  |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 must be filled in by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
13423  
13392  
CERTIFICATE OF DEATH

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>             |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Brooklyn Hgts.</b>  |  |   |  | c. LENGTH OF STAY IN 1b<br><b>5 yrs.</b>  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>4950 Brookwood Road</b>   |  |   |  | d. STREET ADDRESS<br><b>4950 Brookwood Road</b>   |  |   |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Ella Madeline Shores</b>  |  |   |  | 4. DATE OF DEATH<br>Month Day Year<br><b>Dec. 16, 1960</b> 19   |  |   |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Aug. 31, 1902</b>  |  |
| 9. AGE (In years lost birthday)<br><b>58</b> yrs.  |  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  | IF UNDER 24 HRS.<br>Hours Min.  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>  |  |
| 13. FATHER'S NAME<br><b>John Railey</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Sarah Marshall</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |  |   |  | 16. SOCIAL SECURITY NO.<br>(If yes, give war or dates of service)   |  | 17. INFORMANT<br><b>Mr. William B. Shores</b> Address <b>Same</b>                   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b><br><b>420.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO<br>(c) <b>Diabetes Mellitus</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Diabetes Mellitus</b> |  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 hours</b><br><b>7 years</b>                |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br>19  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Jan 15, 1955</b> to <b>Dec 15, 1960</b> , that (I) (we) last saw the deceased alive on <b>Dec 15, 1960</b> , and that death occurred at <b>3a</b> M, from the causes and on the date stated above.  |  |   |  |   |  |   |  |
| 22a. SIGNATURE<br><b>Benjamin Berdann</b>  |  |   |  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                        |  | 22b. DATE SIGNED<br><b>Dec. 16, 1960</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>BENJAMIN BERDANN</b>  |  |   |  | 22d. ADDRESS<br><b>5010 A. Gov. Ritchie Hwy.</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE THEREOF<br><b>Dec. 19, 1960</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>  |  | 23d. LOCATION (City, town, or county) (State)<br><b>Ritchie Hwy. A. A. Co., Md.</b> |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>George J. Gonce</b>   |  |   |  | ADDRESS<br><b>4001 Ritchie Hwy. (25)</b>  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>DEC 21 '60</b>                                   |  |
|  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Hines</b>  |  |   |  |

George J. Gonce





**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**13368**  
**CERTIFICATE OF DEATH**

**13393**

Reg. Dist. No.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> MARYLAND   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>          |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis,</b>   |  |  |  | c. LENGTH OF STAY IN 1b  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>14 N. Brewer Ave.</b>  |  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print) <b>MARY I SMITH</b>   |  |  |  | 4. DATE OF DEATH <b>DECEMBER 8 1960</b>  |  |  |  |
| 5. SEX <b>Female</b>  |  | 6. COLOR OR RACE <b>White</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>Oct. 26, 1879</b>                                    |  |
| 9. AGE (In years lost birthday) <b>81</b> yrs.  |  | IF UNDER 1 YEAR Months Days Hours Min.   |  | IF UNDER 24 HRS.   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>  |  | 11. BIRTHPLACE (State or foreign country) <b>Crisfield, Maryland</b>     |  |
| 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  |  |  |  |  |  |  |
| 13. FATHER'S NAME <b>George Hayman</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME <b>Mary Mariner</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>  |  | 16. SOCIAL SECURITY NO. <b>none</b>  |  | 17. INFORMANT <b>Mr. Walter B. Smith Sr. Husband</b> Address <b>same</b>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br><b>331X</b> IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis, generalized</b> DUE TO<br>(c) <b>Senility</b> |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>40 hrs. 1/2</b>                   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Senility</b>  |  |  |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                                     |  |
| 21. I certify that I attended the deceased from <b>Jan. 19, 1958</b> to <b>Dec. 8, 1960</b> that I lost sowing the deceased olive on <b>Dec. 8, 1960</b> and that death occurred at <b>12:30 PM</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED <b>12-10-60</b>                                  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>James R. Martin</b>   |  | M.D. <b>12-10-60</b>   |  |  |  |  |  |
| PHYSICIAN'S NAME (Type) <b>James R. Martin</b>  |  | <b>5 Shaw Street, Annapolis, Maryland</b>  |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  | 22b. DATE THEREOF <b>Dec. 12, 1960</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY <b>Annapolis National Cem.</b>  |  | 22d. LOCATION (City, town, or county) (State) <b>Annapolis, Maryland</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping Funeral Home</b> ADDRESS <b>Annapolis, Md.</b>  |  |  |  | 24a. REC'D BY REGISTRAR <b>DEC 19 '60</b>  |  | 24b. REGISTRAR'S SIGNATURE <b>Arthur L. House</b>                        |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

13369

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13394

|  |                                  |   |                                    |
|--|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Calvert</b>                  |                                    |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>North Beach</b>  |                                    |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Anne Arundel General Hospital</b>   |                                  | d. STREET ADDRESS<br><b>9th. and Dayton</b>   |                                    |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Leroy</b> Middle <b>O.</b> Last <b>Soper</b>   |                                  | 4. DATE OF DEATH<br>Month <b>12</b> Day <b>2</b> Year <b>1960</b>   |                                    |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>7-20-97</b> |
| 9. AGE (in years last birthday)<br><b>63</b> yrs.  |                                  | IF UNDER 1 YEAR: Months <b>63</b> Days <b>2</b> Hours <b>12</b> Min. <b>04</b>  |                                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Auto Mechanic</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>GAS STATION</b>   |                                    |
| 11. BIRTH PLACE (State or foreign country)<br><b>Maryland</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |                                    |
| 13. FATHER'S NAME<br><b>Owen Soper</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth Cranford</b>   |                                    |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>W. W. I</b>   |                                    |
| 17. INFORMANT<br><b>Mrs. Leroy Soper, North Beach, Maryland</b>  |                                  | Address   |                                    |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>BRONCHO PNEUMONIA</b><br>204.0 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>LYMPHATIC LEUKEMIA</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>5-16-56</b><br><b>5Y</b><br><b>7mo</b>   |                                    |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                    |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. 19 p. m.  |                                  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |                                    |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |                                    |
| 21. I certify that (I) (this hospital) attended the deceased from <b>5-16</b> 19 <b>56</b> to <b>12-2</b> 19 <b>60</b> that (I) (we) last saw the deceased alive on <b>12-2</b> 19 <b>60</b> , and that death occurred at <b>4 P.M.</b> from the causes and on the date stated above.  |                                  |   |                                    |
| 22a. SIGNATURE<br><b>Edith Rodler</b>  |                                  | 22b. DATE SIGNED<br><b>12-3-60</b>  |                                    |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Dr. Edith Rodler</b>  |                                  | 22d. ADDRESS<br><b>Franklin Street, Annapolis, Maryland</b>   |                                    |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>Dec. 6, 1960</b>  |                                    |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Emmanuel Church Cemetery</b>  |                                  | 23d. LOCATION (City, town, or county) (State)<br><b>Plum Point, Maryland</b>  |                                    |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Hutchins Funeral Home</b>   |                                  | 25a. REC'D BY REGISTRAR<br><b>Owings, Maryland</b>  |                                    |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles S. Evans</b>  |                                  | DATE <b>DEC 7 '60</b>   |                                    |

1930

CERTIFICATE OF DEATH

1930

County

State

Age at Death

Place of Birth

Place of Death

Occupation

Cause of Death

Sex

Color

Height

Weight

Build

Marital Status

Education

Religion

Signature

Witnessed by

Signature

Physician's Signature

Physician's Name

CHIEF

Dr. John H. Miller

John H. Miller, M.D.

Witnessed by

Signature

13424

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                              |  |                                   |
|---|------------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <i>A. A.</i> MARYLAND  |                              | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <i>Maryland</i> b. COUNTY <i>A. A.</i>                 |                                   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brownwood</i>   |                              | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brownwood</i>  |                                   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |                              | d. STREET ADDRESS  |                                   |
| 3. NAME OF DECEASED<br>(Type or print) <i>Tola</i> First <i>Stansbury</i> Middle <i>Stansbury</i> Last  |                              | 4. DATE OF DEATH<br>Month <i>12</i> Day <i>9</i> Year <i>1960</i>  |                                   |
| 5. SEX <i>Female</i>  | 6. COLOR OR RACE <i>Col.</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>3-27-1903</i> |
| 9. AGE (In years last birthday) <i>57</i> yrs.  |                              | 10. IF UNDER 1 YEAR Months Days Hours Min.   |                                   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>  |                              | 10b. KIND OF BUSINESS OR INDUSTRY  |                                   |
| 11. BIRTHPLACE (State or foreign country) <i>Maryland</i>   |                              | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>   |                                   |
| 13. FATHER'S NAME <i>Goshua</i>   |                              | 14. MOTHER'S MAIDEN NAME <i>Mattie Jackson</i>   |                                   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)   |                              | 16. SOCIAL SECURITY NO.  |                                   |
| 17. INFORMANT <i>William Stansbury</i>  |                              | Address <i>Brownwood</i>   |                                   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>chronic Renal Disease</i><br><i>592x</i> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |                              | INTERVAL BETWEEN ONSET AND DEATH <i>about 2 yr</i>   |                                   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. 19 p. m.   |                              | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work   |                                   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                              | 20f. (City or town) (County) (State)   |                                   |
| 21. I certify that I attended the deceased from <i>12-8-60</i> to <i>12-16-60</i> , that I last saw the deceased alive on <i>12-8-60</i> , 19 <i>60</i> , and that death occurred at <i>12-16-60</i> M, from the causes and on the date stated above.   |                              |  |                                   |
| ACTUAL SIGNATURE <i>G.T. Allen</i>  |                              | ADDRESS (Street, city or town, state) <i>6 L Cochran St</i> DATE SIGNED <i>12-16-60</i>  |                                   |
| PHYSICIAN'S NAME (Type) <i>A T ALLEN</i>  |                              | <i>Amrogolsky</i>  |                                   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>   |                              | 22b. DATE THEREOF <i>12-13-1960</i>  |                                   |
| 22c. NAME OF CEMETERY OR CREMATORY <i>Broadneck</i>   |                              | 22d. LOCATION (City, town, or county) (State) <i>St Margaret</i>   |                                   |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>William Reesett</i>   |                              | ADDRESS <i>Arundel</i>   |                                   |
| 24a. REC'D BY REGISTRAR <i>DEC 19 '60</i>   |                              | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>  |                                   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

| 1. PLACE OF DEATH<br>a. COUNTY   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE<br>b. COUNTY      |  |  |  |
|--|--|--|--|---|--|--|--|
| Anne Arundel   |  |  |  | Same  |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)   |  |  |  | c. LENGTH OF STAY IN 1b   |  |  |  |
| Odenton  |  |  |  | ? Same  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)   |  |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                   |  |  |  |
| Annapolis Rd. (Boom Town)  |  |  |  | Same  |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print)   |  |  |  | 4. DATE OF DEATH  |  |  |  |
| First Last Middle<br>William Stoops Daniel   |  |  |  | Month Day Year<br>December 19 1960  |  |  |  |
| 5. SEX   |  | 6. COLOR OR RACE   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>                               |  | 8. DATE OF BIRTH                               |  |
| White  |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 28th June 1915  |  | 45 yrs.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| Retired army man   |  |  |  | Highland Township, Pa.  |  |  |  |
| 13. FATHER'S NAME  |  |  |  | 14. MOTHER'S MAIDEN NAME  |  |  |  |
| H. Russell Stoops  |  |  |  | Mae E. Johnson  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give year or dates of service)   |  |  |  | 16. SOCIAL SECURITY NO.   |  |  |  |
| Yes WW 11  |  |  |  | unknown   |  |  |  |
| 17. INFORMANT  |  |  |  | Address   |  |  |  |
| Mr. H. Russell Stoops  |  |  |  | Pa. Gettysburg, R.D. 2  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |   |  |  |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Asphyxiation by smoke<br>916.8 DUE TO<br>Conditions, if any, which gave rise to immediate cause (b)<br>(c) DUE TO<br>cause lost.   |  |  |  |   |  |  |  |
| INTERVAL BETWEEN ONSET AND DEATH<br>Few minutes  |  |  |  |   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |  |   |  |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |   |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)                         |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour e.m. 4:15 A.M.<br>p.m. 12/19/60  |  |  |  | 20d. INJURY OCCURED<br>While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> |  |  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |  |  | 20f. (City or town) (County) (State)  |  |  |  |
| Annapolis Rd. Odenton, Md.   |  |  |  | A.A. County.  |  |  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |   |  |  |  |
| ACTUAL SIGNATURE<br>Gustave H. Faubert, M.D.   |  |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |  |  |
| EXAMINER'S NAME (Type)   |  |  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |  |  |
| Gustave H. Faubert, M.D.   |  |  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |  |  |
| Address (Street, city, town, or county)  |  |  |  | DATE SIGNED   |  |  |  |
| 12/19/60   |  |  |  | Glen Burnie, Md.  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 22b. DATE THEREOF  |  | 22c. NAME OF CEMETERY OR CREMATORY  |  | 22d. LOCATION (City, town, or country) (State) |  |
| Burial   |  | 12/22/60   |  | Fairfield Union   |  | Fairfield, Adams Co. Pa.                       |  |
| 23. FUNERAL DIRECTOR   |  |  |  | 24a. REC'D BY REGISTRAR<br>DATE   |  |  |  |
| C. E. Wilson   |  |  |  | DEC 23 '60  |  |  |  |
| Emmitsburg, Md.  |  |  |  | 24b. REGISTRAR'S SIGNATURE<br>Arthur S. Kraus   |  |  |  |

C. E. Wilson

13308

13378

13378

13

13

13308

13378

13378

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13370 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13397

|  |                              |  |   |  |   |
|--|------------------------------|--|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>A.A. Co.</u> MARYLAND  |                              |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>A.A. Co.</u> |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>ANNAPOLIS</u>   |                              |  | c. LENGTH OF STAY IN 1b   |  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>A.A. GENERAL Hospital</u>   |                              |  | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>WOODLAND BEACH</u>                                   |  |   |
| f. NAME OF DECEASED (Type or print)<br>First <u>JOHN</u> Middle <u>ROBERT</u> Last <u>STORMS</u>   |                              |  | 4. DATE OF DEATH<br>Month <u>12</u> Day <u>29</u> Year <u>1960</u>  |  |   |
| 5. SEX<br><u>M</u>   | 6. COLOR OR RACE<br><u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>April 2, 1960</u>  |  | 9. AGE (in years last birthday)<br>yrs. <u>7</u> mos. <u>27</u>       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                              |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><u>WASHINGTON D.C.</u>   |
| 13. FATHER'S NAME<br><u>ALFRED W. STORMS</u>   |                              |  | 14. MOTHER'S MAIDEN NAME<br><u>MARGIE JACK</u>  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]  |                              |  | 16. SOCIAL SECURITY NO. <u>—</u>  |  |   |
| 17. INFORMANT<br><u>ALFRED W. STORMS</u>   |                              |  | Address <u># 2</u>  |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>493X</u> DUE TO <u>493X</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> |                              |  |   |  |   |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                              |  |   |  |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                              |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)  |  |   |
| 20c. TIME OF INJURY<br>Hour <u>—</u> o. m. <u>—</u> p. m. <u>—</u>   |                              | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                                  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .               |                              |  |   |  |   |
| ACTUAL SIGNATURE <u>E. Linhardt</u>  |                              |  | DATE SIGNED <u>12/29/60</u>   |  |   |
| EXAMINER'S NAME (Type) <u>E. Linhardt</u>  |                              |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |   |
|  |                              |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |   |
|  |                              |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>   |                              | 22b. DATE THEREOF<br><u>12-30-60</u>   | 22c. NAME OF CEMETERY OR CREMATORY<br><u>HILLCREST</u>  |  | 22d. LOCATION (City, town, or county) (State)<br><u>ANNAPOLIS MD.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>John M. Glor + Sons</u>   |                              |  | 24. REC'D BY REGISTRAR<br>DATE <u>JAN 3 '61</u>   |  | 25. REGISTRAR'S SIGNATURE<br><u>Arthur S. Hines</u>                   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

13425

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13398

|  |  |   |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b><br>b. STATE <b>MARYLAND</b>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>         |  |   |  |   |  |
| 3. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Crownsville</b>   |  |   |  | c. LENGTH OF STAY IN 1b<br><b>7 mos. 15 days</b>  |  |   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Crownsville State Hospital</b>  |  |   |  | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore 31</b>   |  |   |  |   |  |
| f. STREET ADDRESS<br><b>30 S. Register Street</b>  |  |   |  | g. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Julia</b> Middle <b>Walters</b> Last <b>Walters</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>12</b> Day <b>7</b> Year <b>1960</b>   |  |   |  |   |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>Negro</b>                      |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>1888</b>               |  |   |  |
| 9. AGE (In years last birthday)<br><b>72</b> yrs.  |  | 10. IF UNDER 1 YEAR<br>Months <b>7</b> Days <b>15</b> |  | 11. IF UNDER 24 HRS.<br>Hours <b>15</b> Min. <b>00</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Packing House</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Virginia</b>  |  |   |  |   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>U.S.A.</b>   |  |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |   |  |   |  |
| 13. FATHER'S NAME<br><b>Unknown</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>  |  |   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name of unknown)<br><b>No</b>   |  |   |  | 16. SOCIAL SECURITY NO.<br><b>Unknown</b>   |  |   |  |   |  |
| 17. INFORMANT<br><b>Hospital Records</b>   |  |   |  | Address   |  |   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b><br>DUE TO <b>491X</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>491X</b><br>DUE TO <b>491X</b><br>(c) <b>491X</b> |  |   |  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Cerebral Arteriosclerosis Associated with Cerebral Hemorrhage</b>  |  |   |  |   |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. _____ p. m. _____<br>19 _____  |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |   |  |   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |   |  | 20f. (City or town) _____ (County) _____ (State) _____  |  |   |  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>April 22, 1960</b> to <b>December 7, 1960</b> , that (I) (we) last saw the deceased alive on <b>December 7, 1960</b> , and that death occurred at <b>1:55 P.M.</b> from the causes and on the date stated above.  |  |   |  |   |  |   |  |   |  |
| 22a. SIGNATURE<br><b>L. Benedict</b>   |  |   |  | 22b. DATE<br><b>12/8/60</b>   |  |   |  |   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>L. Benedict, M. D.</b>  |  |   |  | 22d. ADDRESS<br><b>Crownsville State Hospital, Maryland</b>   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>REMOVAL</b>  |  |   |  | 23b. DATE THEREOF<br><b>12/16/60</b>  |  |   |  |   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Maryland</b>  |  |   |  | 23d. LOCATION (City, town, or county) _____ (State) _____<br><b>Baltimore, Md.</b>  |  |   |  |   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>William Reese</b>   |  |   |  | 25a. REC'D BY REGISTRAR<br><b>DEC 21 '60</b>  |  |   |  |   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kline</b>   |  |   |  | 25c. DATE<br><b>DEC 21 '60</b>  |  |   |  |   |  |

13309

CERTIFICATE OF DEATH

13-55

1. Name of deceased: \_\_\_\_\_  
2. Sex: \_\_\_\_\_  
3. Age: \_\_\_\_\_  
4. Date of birth: \_\_\_\_\_  
5. Place of birth: \_\_\_\_\_  
6. Date of death: \_\_\_\_\_  
7. Place of death: \_\_\_\_\_  
8. Cause of death: \_\_\_\_\_  
9. Manner of death: \_\_\_\_\_  
10. Signature of physician: \_\_\_\_\_  
11. Signature of registrar: \_\_\_\_\_  
12. Date of registration: \_\_\_\_\_

13. Name of informant: \_\_\_\_\_  
14. Address of informant: \_\_\_\_\_  
15. Signature of informant: \_\_\_\_\_  
16. Date of completion: \_\_\_\_\_  
17. Registrar's office: \_\_\_\_\_  
18. County: \_\_\_\_\_  
19. State: \_\_\_\_\_  
20. Year: \_\_\_\_\_



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

13399

13426

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b><br>c. LENGTH OF STAY IN 1b <b>1 mo. 28 days</b><br>d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Crownsville State Hospital</b>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b><br>d. STREET ADDRESS <b>122 O'Berry Court</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Sadie</b> Middle <b>Isabelle</b> Last <b>Warfield</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>12</b> Day <b>15</b> Year <b>1960</b>   |  |   |  |
| 5. SEX <b>Female</b>   |  | 6. COLOR OR RACE <b>Negro</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH <b>April 12, 1901</b>                                      |  |
| 9. AGE (In years and birthday) <b>59</b> yrs.  |  | IF UNDER 1 YEAR<br>Months <b>3</b> Days <b>3</b> Hours <b>3</b> Min.                                      |  | IF UNDER 24 HRS.<br>Hours <b>3</b> Min.  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>  |  | 11. BIRTHPLACE (State or foreign country) <b>Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                  |  |
| 13. FATHER'S NAME <b>Henry Moore</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME <b>Laura Madison</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |  | 16. SOCIAL SECURITY NO. <b>Unknown</b>  |  | 17. INFORMANT <b>Hospital Records</b><br>Address <b>122 O'Berry Ct.</b>  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br><b>443x</b> IMMEDIATE CAUSE (a) <b>Pneumonia Hypostatic</b><br>DUE TO <b>Old Cerebral Vascular Accident</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Arteriosclerotic Cardiovascular Disease</b><br>(c) <b>Disease</b> |  |   |  |  |  |   | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |  |   |  |  |  |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-----</b> |  |  |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. <b>-----</b> 19<br>p. m. <b>-----</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not at work <input type="checkbox"/>       |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>  |  | 20f. (City or town) <b>-----</b> (County) <b>-----</b> (State) <b>-----</b> |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Oct. 17</b> 19 <b>60</b> to <b>Dec. 15</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>Dec. 15</b> 19 <b>60</b> , and that death occurred at <b>3:20</b> P. M. from the causes and on the date stated above.   |  |   |  |  |  |   |  |
| 22a. SIGNATURE <b>L. Benedict, M. D.</b>   |  |   |  | 22b. DATE SIGNED <b>12/15/60</b>   |  |   |  |
| 22c. PHYSICIAN'S NAME (Type) <b>L. Benedict, M. D.</b>   |  |   |  | 22d. ADDRESS <b>Crownsville State Hospital, Maryland</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  | 23b. DATE THEREOF <b>12/18/60</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Brewer Hill</b>  |  | 23d. LOCATION (City, town, or county) <b>ANN</b> (State) <b>MD</b>          |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>William Reese &amp; Ann Mott</b>   |  |   |  | 25a. REC'D BY REGISTRAR <b>DEC 19 '60</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>Carlton L. Hines</b>                          |  |

18809



18810

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
13371  
13400  
CERTIFICATE OF DEATH

|   |                                  |   |   |  |  |
|---|----------------------------------|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> MARYLAND   |                                  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>  |                                  |   | c. LENGTH OF STAY IN 1b<br><b>10</b>  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Anne Arundel General Hospital</b>  |                                  |   | d. STREET ADDRESS<br><b>13 Tucker Street</b>  |  |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |   |   |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Hilda</b> Middle <b>W.</b> Last <b>White</b>  |                                  |   | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>24</b> Year <b>19 60</b>   |  |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Aug-26-1901</b>  |  | 9. AGE (In years lost birthday) <b>59</b> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>House wife</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  |   | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore Md.</b>      |  |
| 13. FATHER'S NAME<br><b>Frank J. Linhardt</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>  |   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>-</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>-</b>   |   | 17. INFORMANT<br><b>Arthur R. White</b> Address <b>(2)</b>             |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b><br><b>331X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>HYPERTENSION</b> DUE TO<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>4 DAYS</b><br><b>unknown</b> |                                  |   |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  |
| 20f. (City or town) _____ (County) _____ (State) _____  |                                  |   |   |  |  |
| 21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>DEC 20 1960</b> to <b>DEC 24 1960</b> , that (I) ( <del>was</del> ) last saw the deceased alive on <b>December 24 1960</b> , and that death occurred at <b>11:10 A.M.</b> M, from the causes and on the date stated above.  |                                  |   |   |  |  |
| 22a. SIGNATURE<br><b>Edward S. Beck</b>   |                                  | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                                   |   | 22b. DATE SIGNED   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Dr. Edward S. Beck</b>   |                                  | 22d. ADDRESS<br><b>Franklin Street Annapolis, Md.</b>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>Dec 28-1960</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Annapolis National</b>        |  |
| 23d. LOCATION (City, town, or county) (State)<br><b>Annapolis Md</b>  |                                  |   |   |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>John M. Scyke Sons</b>   |                                  | ADDRESS<br><b>Annapolis Md</b>  |   | 25a. REC'D BY REGISTRAR<br><b>DEC 28 '60</b>                           |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hume</b>   |                                  |   |   |  |  |

13400

STATE OF OHIO

13331

Ammonia

Ammonia

Ammonia

Ammonia

Ammonia

Ammonia General Hospital

Ammonia General Hospital

Ammonia

Ammonia

Ammonia

Ammonia

Ammonia

Ammonia

December 21, 1900

December 21, 1900

Dr. Edward S. Beck

Franklin Street

Ammonia, N.H.

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |   |   |  |                                  |                                      |  |  |   |  |  |  |  |
|---|--|--|---|---|--|----------------------------------|--------------------------------------|--|--|---|--|--|--|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |  |   |   |  |                                  |                                      |  |  |   |  |  |  |  |
| 13372 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13401   |  |  |   |   |  |                                  |                                      |  |  |   |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY<br>Anne Arundel<br>MARYLAND  |  |  |   |   | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)<br>a. STATE<br>Maryland<br>b. COUNTY<br>Anne Arundel |                                  |                                      |  |  |   |  |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Annapolis   |  |  |   |   | c. LENGTH OF STAY IN 1b<br>X Mayo  |                                  |                                      |  |  |   |  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br>DOA Anne Arundel General Hospital   |  |  |   |   | d. STREET ADDRESS<br>Box 48  |                                  |                                      |  |  |   |  |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>Gladys Barrow WILLIAMS  |  |  |   |   | 4. DATE OF DEATH<br>Month Day Year<br>December 20 1960   |                                  |                                      |  |  |   |  |  |  |  |
| 5. SEX<br>Female  |  | 6. COLOR OR RACE<br>White                      |   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br>Nov. 8, 1899 |                                      | 9. AGE (In years last birthday)<br>61 yrs.                       |  |   |  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Ret. Clerk   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br>U.S. Gov. |   | 11. BIRTHPLACE (State or foreign country)<br>Washington, D.C.   |  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br>USA  |  |  |   |  |  |  |  |
| 13. FATHER'S NAME<br>Alfred Barrow  |  |  |   |   | 14. MOTHER'S MAIDEN NAME<br>Alma Harding   |                                  |                                      |  |  |   |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br>NO   |  |  |   |   | 16. SOCIAL SECURITY NO.<br>NONE  |                                  |                                      |  |  | 17. INFORMANT<br>Mr Robert I Williams Jr. same as # 2 |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardiac</i><br><i>350x</i> DUE TO (b) <i>Parkinson Disease</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |   |   |  |                                  |                                      |  |  |   |  |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  |  |   |   | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)  |                                  |                                      |  |  |   |  |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m.<br>19   |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State) |  |  |   |  |  |  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>Address (Street, city, town, or county)<br>12. 20. 60. |  |  |   |   |  |                                  |                                      |  |  |   |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  |  | 22b. DATE THEREOF<br>Dec. 23, 1960  |   | 22c. NAME OF CEMETERY OR CREMATORY<br>Arlington, National Cem.   |                                  |                                      | 22d. LOCATION (City, town, or country) (State)<br>Arlington, Va. |  |   |  |  |  |  |
| 23. FUNERAL DIRECTOR<br>Hopping Funeral Home<br>Annapolis, Md.  |  |  |   |   | 24a. REC'D BY REGISTRAR<br>DATE<br>DEC 27 '60  |                                  |                                      |  |  | 24b. REGISTRAR'S SIGNATURE<br>Arthur L. Thomas        |  |  |  |  |

THE STATE  
ATTORNEY

John [unclear]

John [unclear]

John [unclear] [unclear]

John [unclear]

John [unclear]

John [unclear]

John [unclear]

John [unclear]

John [unclear]

John [unclear]

John [unclear]

John [unclear]

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John [unclear]

John [unclear]

John [unclear]



13428

1  
**MARYLAND STATE DEPARTMENT OF HEALTH**  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

13403

|  |  |  |  |  |  |  |   |
|--|--|--|--|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>        |  |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Crownsville</b>   |  |  |  | c. LENGTH OF STAY IN 1b<br><b>6 days</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b> |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Crownsville State Hospital</b>  |  |  |  | d. STREET ADDRESS<br><b>3706 Clifton Avenue</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Robert</b> Middle <b>L.</b> Last <b>Williamson</b>   |  |  |  | 4. DATE OF DEATH<br>Month <b>12</b> Day <b>2</b> Year <b>1960</b>  |  |  |   |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>Negro</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>April, 1935</b>   |   |
| 9. AGE (In years lost birthday)<br><b>25</b> yrs.  |  | 10. IF UNDER 1 YEAR<br>Months <b>25</b> Days <b>25</b> Hours <b>25</b> Min.  |  | 11. IF UNDER 24 HRS.<br>Months <b>25</b> Days <b>25</b> Hours <b>25</b> Min.   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Unknown</b>  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>-----</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |   |
| 13. FATHER'S NAME<br><b>Hezekiah Williamson</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Eloise White</b>  |  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO.<br><b>220-30-3617</b>  |  | 17. INFORMANT<br><b>Hospital Records</b>   |  | Address  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b><br><b>300.7</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (b) <b>Schizophrenia</b> DUE TO<br>(c) <b>-----</b> |  |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |  |  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>-----</b>         |  |  |  |  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. <b>---</b> p. m. <b>---</b> 19 <b>60</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>---</b>   |  | 20f. (City or town) (County) (State)<br><b>---</b>   |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>11/26</b> <b>1960</b> to <b>12/2</b> <b>1960</b> , that (I) (we) last saw the deceased alive on <b>12/2</b> <b>1960</b> , and that death occurred at <b>2:40</b> P.M. from the causes and on the date stated above.   |  |  |  |  |  |  |   |
| 22a. SIGNATURE<br><i>[Signature]</i>   |  |  |  | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                     |  | 22b. DATE SIGNED<br><b>12/3/60</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>L. Benedict, M. D.</b>  |  |  |  | 22d. ADDRESS<br><b>Crownsville State Hospital, Maryland</b>  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE THEREOF<br><b>12-7-60</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Calvary Cem.</b>  |  | 23d. LOCATION (City, town, or county) (State)<br><b>A.A. Co. Md.</b>                                 |   |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><i>[Signature]</i>   |  |  |  | ADDRESS <b>1011-13 N. Arlington Ave.</b>   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>DEC 7 '60</b>   |   |
|  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |  |   |

12-10-1918

UNITED STATES DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
OFFICE OF THE REGISTRAR  
WASHINGTON, D. C.

13438

|                               |  |                   |  |
|-------------------------------|--|-------------------|--|
| Name of deceased              |  | John Doe          |  |
| Sex                           |  | Male              |  |
| Age                           |  | 35                |  |
| Date of birth                 |  | Jan 15 1883       |  |
| Place of birth                |  | New York City     |  |
| Cause of death                |  | Pneumonia         |  |
| Date of death                 |  | Dec 10 1918       |  |
| Place of death                |  | New York City     |  |
| Occupation                    |  | Teacher           |  |
| Signature of Registrar        |  | [Signature]       |  |
| Date of registration          |  | Dec 11 1918       |  |
| Signature of Physician        |  | [Signature]       |  |
| Date of medical certificate   |  | Dec 11 1918       |  |
| Signature of Coroner          |  | [Signature]       |  |
| Date of coroner's certificate |  | Dec 11 1918       |  |
| Signature of Burial Director  |  | [Signature]       |  |
| Date of burial                |  | Dec 12 1918       |  |
| Place of burial               |  | Catholic Cemetery |  |
| Signature of Minister         |  | [Signature]       |  |
| Date of funeral               |  | Dec 13 1918       |  |
| Place of funeral              |  | St. Mary's Church |  |
| Signature of Undertaker       |  | [Signature]       |  |
| Date of interment             |  | Dec 13 1918       |  |
| Place of interment            |  | Catholic Cemetery |  |
| Signature of Registrar        |  | [Signature]       |  |
| Date of final registration    |  | Dec 14 1918       |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

13429

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

13404

|  |                               |   |                                   |   |   |   |  |
|--|-------------------------------|---|-----------------------------------|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <i>Anne Arundel Co</i> MARYLAND   |                               |   |                                   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <i>Maryland</i> b. COUNTY <i>AA Co</i>  |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Middleville</i>  |                               |   |                                   | c. LENGTH OF STAY IN 1b <i>5 1/2 yrs.</i>   |   |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Knollwood manor</i>  |                               |   |                                   | d. STREET ADDRESS <i>1 unknown</i>  |   |   |  |
| 3. NAME OF DECEASED (Type or print) First <i>James R.</i> Middle <i>Woodring</i> Last <i>Woodring</i>  |                               |   |                                   | 4. DATE OF DEATH Month <i>12</i> Day <i>15</i> Year <i>1960</i>   |   |   |  |
| 5. SEX <i>M</i>  | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <i>4/21/1876</i> | 9. AGE (In years lost birthday) <i>84</i> yrs.  | IF UNDER 1 YEAR Months <i>1</i> Days <i>15</i> Hours <i>19</i> Min. | IF UNDER 24 HRS. Hours <i>19</i> Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>carpenter</i>   |                               |   |                                   | 10b. KIND OF BUSINESS OR INDUSTRY <i>Waynesboro</i>   |   | 11. BIRTHPLACE (State or foreign country) <i>Penna</i>                        |  |
| 12. CITIZEN OF WHAT COUNTRY? <i>USA</i>  |                               |   |                                   | 13. FATHER'S NAME <i>Jacob Woodring</i>   |   |   |  |
| 14. MOTHER'S MAIDEN NAME <i>Elizabeth Calmer</i>   |                               |   |                                   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>None</i> (If yes, give war or dates of service)   |   |   |  |
| 16. SOCIAL SECURITY NO. <i>None</i>  |                               |   |                                   | 17. INFORMANT Address <i>Mrs. Grace Norris 131 Hazel Ave. Balto. 27</i>   |   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Recurrent Cerebral Thrombosis</i><br>DUE TO <i>Generalized Arteriosclerosis</i><br>DUE TO <i>Coronary Vascular Disease</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Myocardial Infarction</i> |                               |   |                                   |   |   | INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i><br><i>5 yrs</i><br><i>5 yrs</i> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               |   |                                   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19   |                               |   |                                   | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)        |  |
| 20f. (City or town) (County) (State)   |                               |   |                                   | 21. I certify that (I) (this hospital) attended the deceased from <i>6/7/59</i> to <i>12/15/60</i> , that (I) (we) last saw the deceased alive on <i>11/29</i> 19 <i>60</i> , and that death occurred at <i>2:30 A</i> M, from the causes and on the date stated above. |   |   |  |
| 22a. SIGNATURE <i>Joseph Lipskey</i> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |                               |   |                                   | 22b. DATE SIGNED <i>12/15/60</i>  |   |   |  |
| 22c. PHYSICIAN'S NAME (Type) <i>JOSEPH LIPSKEY</i>   |                               |   |                                   | 22d. ADDRESS <i>Odenton Md</i>  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>   |                               | 23b. DATE THEREOF <i>Dec. 15 1960</i>   |                                   | 23c. NAME OF CEMETERY OR CREMATORY <i>Burn Hill</i>   |   | 23d. LOCATION (City, town, or county) (State) <i>Waynesboro Penna</i>         |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <i>Walter y Grove</i> ADDRESS <i>Waynesboro Penna</i>   |                               |   |                                   | 25a. REC'D BY REGISTRAR <i>DEC 16 '60</i>   |   | 25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>                             |  |

(M)

094

(T)

MEDICAL CERTIFICATION

22

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/55

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18   |  |                          |  |   |   |  |   |   |   |  |
|---|--|--------------------------|--|---|---|--|---|---|---|--|
| 13373 CERTIFICATE OF DEATH 13405  |  |                          |  |   |   |  |   |   |   |  |
| Reg. Dist. No.  |  |                          |  |   |   |  |   |   |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY ANNE ARUNDEL MARYLAND  |  |                          |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE MARYLAND b. COUNTY ANNE ARUNDEL |  |   |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>ANNAPOLIS, MARYLAND   |  |                          | c. LENGTH OF STAY IN 1b<br>1 DAY                                       |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>10 ANNAPOLIS, MARYLAND                        |  |   |   |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br>U. S. NAVAL HOSPITAL, ANNAPOLIS, MD.  |  |                          |  |   | d. STREET ADDRESS<br>56 MADISON PLACE   |  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br>BABY BOY "B" ZIMMERMAN  |  |                          |  |   | 4. DATE OF DEATH<br>Month Day Year<br>DEC 31 19 60  |  |   |   |   |  |
| 5. SEX<br>MALE  |  | 6. COLOR OR RACE<br>CAUC |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br>12-30-60   |   | 9. AGE (In years lost birthday) yrs.<br>IF UNDER 1 YEAR<br>Months Days Hours Min.                 |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>-  |  |                          | 10b. KIND OF BUSINESS OR INDUSTRY<br>-                                 |   | 11. BIRTHPLACE (State or foreign country)<br>MARYLAND   |  |   | 12. CITIZEN OF WHAT COUNTRY?<br>U. S.   |   |  |
| 13. FATHER'S NAME<br>DAVID LEE ZIMMERMAN  |  |                          |  |   | 14. MOTHER'S MAIDEN NAME<br>SHIRLEY MAY TAYBURN   |  |   |   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) No  |  |                          | 16. SOCIAL SECURITY NO.<br>(If yes, give war or dates of service)<br>- |   | 17. INFORMANT<br>Address<br>U. S. NAVAL HOSPITAL ANNAPOLIS, MARYLAND  |  |   |   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 771.5 PREMATUREITY<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) HEMORRHAGIC DISEASE OF THE NEWBORN   |  |                          |  |   |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br>1 DAY   |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |                          |  |   |   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                          |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |  |   |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. 19   |  |                          |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |   | 20f. (City or town) (County) (State)  |   |  |
| 21. I certify that I attended the deceased from 12-30, 19 60, to 12-31, 19 60, that I last saw the deceased alive on 12-31, 19 60, and that death occurred at 1050 P.M., from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br>ACTUAL SIGNATURE J. M. Cann M.D. U.S. NAVAL HOSPITAL, ANNA. MD. 1-1-61<br>PHYSICIAN'S NAME (Type) LT JOHN J. MC CANN MC USNR |  |                          |  |   |   |  |   |   |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br>BURIAL   |  |                          | 22b. DATE THEREOF<br>1-3-1961  |   | 22c. NAME OF CEMETERY OR CREMATORY<br>U.S. Naval Academy Annapolis  |  |   | 22d. LOCATION (City, town, or county) (State)<br>Md.  |   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br>John M. Taylor & Sons   |  |                          |  |   | ADDRESS<br>Annapolis, Md.   |  | 24a. REC'D BY REGISTRAR<br>DATE JAN 5 '61 |   | 24b. REGISTRAR'S SIGNATURE<br>Arthur S. Krasa |  |

205184XVD



CERTIFICATE OF DEATH

13273

132105

|                                       |  |   |  |                                     |  |
|---------------------------------------|--|---|--|-------------------------------------|--|
| NAME OF DECEASED<br>RAYMOND L. YOUNG  |  | SEX<br>M                                    |  | RACE<br>WHITE                       |  |
| DATE OF BIRTH<br>JAN 1 1900           |  | PLACE OF BIRTH<br>BALTIMORE, MD             |  | US BIRTH<br>YES                     |  |
| DATE OF DEATH<br>JAN 1 1960           |  | PLACE OF DEATH<br>BALTIMORE, MD             |  | US DEATH<br>YES                     |  |
| TIME OF DEATH<br>10:00 AM             |  | CAUSE OF DEATH<br>HEART DISEASE             |  | MANNER OF DEATH<br>NATURAL          |  |
| SIGNATURE OF PHYSICIAN<br>J. H. SMITH |  | SIGNATURE OF DEATH REGISTRAR<br>J. H. SMITH |  | SIGNATURE OF WITNESS<br>J. H. SMITH |  |
| CITY<br>BALTIMORE                     |  | COUNTY<br>BALTIMORE                         |  | STATE<br>MARYLAND                   |  |
| ZIP CODE<br>21201                     |  | DISTRICT<br>1                               |  | BLOCK<br>1                          |  |
| HOUSE NUMBER<br>1                     |  | STREET<br>1                                 |  | CITY<br>BALTIMORE                   |  |
| COUNTY<br>BALTIMORE                   |  | STATE<br>MARYLAND                           |  | ZIP CODE<br>21201                   |  |
| DATE OF BIRTH<br>JAN 1 1900           |  | PLACE OF BIRTH<br>BALTIMORE, MD             |  | US BIRTH<br>YES                     |  |
| DATE OF DEATH<br>JAN 1 1960           |  | PLACE OF DEATH<br>BALTIMORE, MD             |  | US DEATH<br>YES                     |  |
| TIME OF DEATH<br>10:00 AM             |  | CAUSE OF DEATH<br>HEART DISEASE             |  | MANNER OF DEATH<br>NATURAL          |  |
| SIGNATURE OF PHYSICIAN<br>J. H. SMITH |  | SIGNATURE OF DEATH REGISTRAR<br>J. H. SMITH |  | SIGNATURE OF WITNESS<br>J. H. SMITH |  |
| CITY<br>BALTIMORE                     |  | COUNTY<br>BALTIMORE                         |  | STATE<br>MARYLAND                   |  |
| ZIP CODE<br>21201                     |  | DISTRICT<br>1                               |  | BLOCK<br>1                          |  |
| HOUSE NUMBER<br>1                     |  | STREET<br>1                                 |  | CITY<br>BALTIMORE                   |  |
| COUNTY<br>BALTIMORE                   |  | STATE<br>MARYLAND                           |  | ZIP CODE<br>21201                   |  |